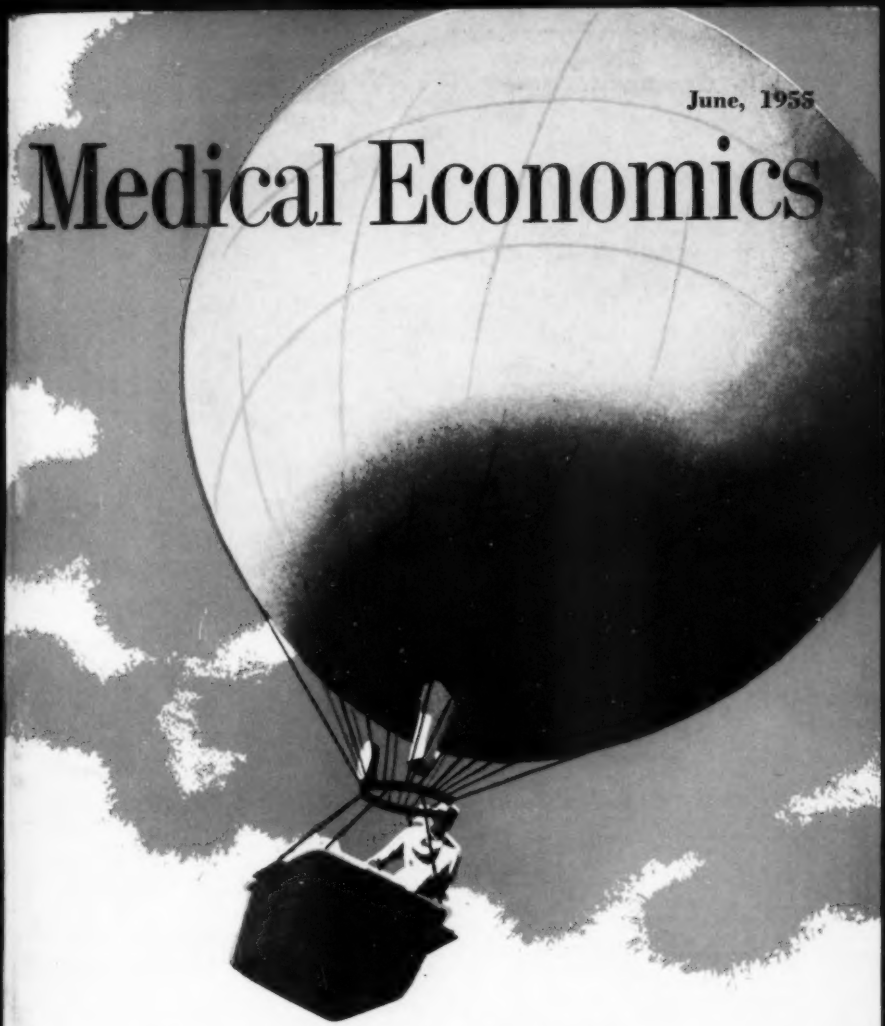
June, 1955

Medical Economics



Are Surgical Fees Too High?

The long and short of Bentyl's relief of nervous gut

Clinicians[1,2] prove Bentyl is long on effective relief... short on unwanted side effects including blurred vision and dry mouth.

1. McHardy and Browne: Sou. Med. J. 45:1139, 1952. 2. Lorber and Shay: Fed. Proc. 12:90, 1952.

Complete Bentyl bibliography on request.

BENTYL

(dicyclomine hydrochloride)

another exclusive development of Merrell research

Rx INFORMATION

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Bentyl affords direct (musculotropic) and indirect (neurotropic) spasmolytic action. Bentyl provides complete and comfortable relief in smooth muscle spasm, particularly in functional G.I. disorders, in irritable colon, pylorospasm, biliary tract dysfunction and spastic constipation.

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JUNE, 1955

Medical Economics

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Published monthly by Medical Economics, Inc., at Oradell, N.J. Price 50 cents a copy, $5 a year (Canada and foreign, $6). Circulation, 136,000 physicians and residents. Accepted as a controlled circulation publication at the Post Office at Rutherford, N.J. PICTURE CREDITS (left to right, top to bottom): cover, 97, Bern Hill; 5, Al Kaufman; 6, Merle Junk, Olympic; 99, Walter Daran; 102-103, Reet Thomas; 110, Westinghouse Electric Corp.; 111, Raytheon Mfg. Co.; 116, General Motors; 117, Ford Motor Co.; 120-123, Fables Publishing Co.; 124, Edgar S. Brinker; 128, Walter Reed Army Medical Center; 129, Wilmot Castle; 132, Moulin; 133, John Black & Associates. CARTOON CREDITS: 143, 279, Malcolm MacNeily; 155, Charles Strauss; 159, Doris Matthews; 171, Jack Schade; 189, Dick Weinert; 206, William Thomson; 210, Tom Blakley; 213, Bo Brown; 241, John Gallagher.

Panorama

Legislature creates new medical disciplinary board • Are doctors poor marriage risks? • Electronic Rx-transmitter unveiled • Seek heavier penalty for fake M.D.s • Polio foundation turmoil: a case study

Less for Lobbying

A.M.A. expenditures for lobbying have been shrinking steadily since 1950 (when the association spent a whopping $1,326,077 to put its message before Congress). The outlay in 1954 was a mere $39,120—the smallest total since 1947, and less than half the amount spent in 1953 ($106,624).

This downward trend doesn't mean that the A.M.A. has become less vigilant. As this issue went to press, it was preparing to fight a number of the health bills pending before the present Congress. But none of them posed the kind of *big* threat that once required an all-out campaign.

What lobbying money is spent in 1955 will go toward battling such measures as the following (to which the A.M.A. Board of Trustees has pledged "active opposition"):

¶ The Administration's reinsurance program;

¶ Extension of the doctor draft;

¶ Additional medical care for dependents of armed forces personnel;

¶ Mortgage loan insurance for hospitals and medical facilities;

¶ The establishment of a U.S. Armed Forces Medical Academy;

¶ Free hospitalization for the aged under the Social Security Act;

¶ *Compulsory* Social Security for self-employed physicians.

Supreme Court Upholds 'Visual Care' Law

The individual states have a legal right to decide who can perform specific optical services. What's more, they may, if they choose, regulate the sale and advertising of eyeglasses. So ruled the U. S. Supreme Court recently, in upholding Oklahoma's long-disputed "visual care" statute.

First enacted in 1953, the Oklahoma law limits the prescription of glasses to ophthalmologists and optometrists. It also outlaws the advertising of glasses. And it forbids

department stores to lease space for eye examinations.

The state's opticians (who are strong and numerous) naturally set up a howl. So did a Texas-Oklahoma chain of eyeglass-making shops. Eventual upshot of the controversy: A lower Federal court declared the statute unconstitutional.

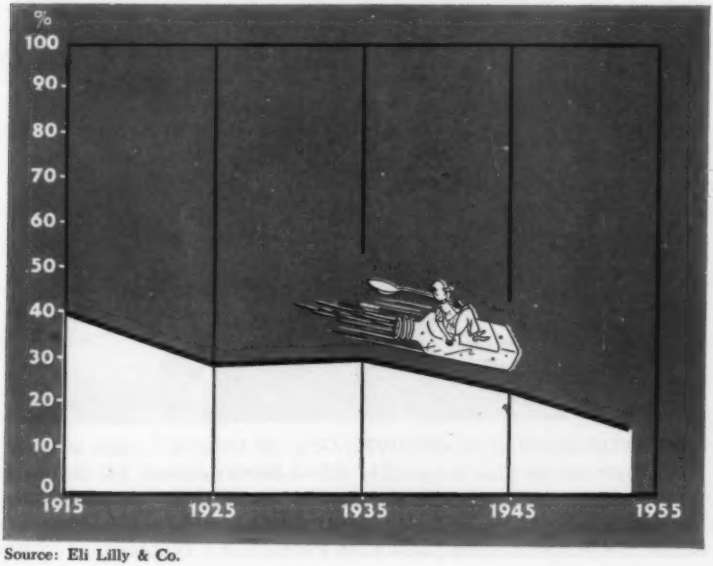
But the state's Attorney General, citing similar laws in seventeen other states, fought the issue up to the Supreme Court. And there, the lower court decision was quickly and unanimously reversed.

New Disciplinary Board

Thanks to a recently enacted law, physicians in the State of Washington now have state governmental support for their all-out effort to

Doctor Dispensing Dwindles

This chart shows the gradual but steady decline in the percentage of physicians who fill half or more of their own prescriptions.



Source: Eli Lilly & Co.

"clean house." What's more, the medical men also have the necessary machinery with which to do the job effectively.

The legislation—said to be the first of its kind in the country—sets up a special disciplinary board. Made up entirely of physicians (one from each congressional district, elected by his colleagues), it will hear complaints of unethical practice and will have power to mete out appropriate punishment.

Comments state medical association President M. Shelby Jared: "This law makes it possible for us to police ourselves adequately for the first time. In the past, a physician guilty of unprofessional conduct could be punished only by revocation of his license. This is a severe penalty applicable only to major infractions and was rarely invoked. Until this legislation went through, there was no provision for suspension of license or for other disciplin-



NEW DISCIPLINARY LAW APPROVED: Governor Arthur B. Langlie of Washington State puts his signature on H.B. 365—a doctor-sponsored bill that gives the profession official authority to discipline its own members. The pleased doctors looking on are M. Shelby Jared (seated), president of the state medical association, and doctor-legislators James L. McFadden and A. O. Adams.

ary action for minor offenses committed by doctors."

Other Washington physicians seem equally pleased. They point out that, for one thing, the law is eminently fair. Every accused has full protection: He can appeal the board's decision; he's guaranteed eventual reinstatement if his offense is adjudged a minor one; and he's assured that every effort will be made to clear his name if the charge against him turns out to be unfounded.

No Prima Donnas Wanted

These days, it's easy to find girls who want to work as doctors' aides. In fact, competition for such jobs has become so stiff that girls are "groomed for [them] like debutantes for their presentation," declares Dr. Leo J. Adelstein of Los Angeles.

The trouble is, this wealth of material hasn't made it any easier for a doctor to find a really *good* assistant, Dr. Adelstein complains. In a recent issue of The Pulse (monthly bulletin of the Medical Assistants Association), he states his case in these words:

"The woods are full of candidates, each like a prima donna, panting to exhibit her ability as a performer."

But, he asks, "where is the girl with a healthy mental outlook and well-disciplined emotions, eager to be of service to her doctor and her world?"

[MORE ▶

Snapshots

2,147 PRESCRIPTIONS were written last year by the average U.S. physician, says the American Druggist magazine. It adds that the average family in 1954 spent $22.37 on prescriptions and that the average Rx price was $2.56, or 12 cents higher than in 1953.

MORE REALISTIC TV: When "Medic" is telecast again in the fall, more clinical detail can be expected by viewers. The camera may show actual incisions and operating techniques, says John M. Lucas, director of the series. That's what "the public wants," he explains.

LIBRARIANS FILL RX: A Milwaukeean startled the public library staff by asking them (instead of the corner druggist) to fill his doctor's prescription. The Rx called for two books: "Thank God for My Heart Attack" and "Release From Nervous Tension."

THE SHRUNKEN DOLLAR has stopped shrinking—at least for the time being. If the dollar is assumed to have had a buying power of 100 cents in 1939, then by 1952 it was worth 52 cents. Since then, it has scarcely budged, says U.S. News & World Report.



DR. LEO J. ADELSTEIN

A good aide is hard to find



PAUL POPENOE

Do doctors make lousy husbands?

That's the only kind of girl for him, insists Dr. Adelstein. As for the prima donna, he says, "refer her to Central Casting!"

Doctors Called Poor Marriage Risk

"Physicians have very nearly the highest divorce rate of all professions . . . exceeded only by actors, artists, and traveling men." That's what marriage counselor Paul Popenoe told a young woman recently in one of his syndicated newspaper columns.

Of course, he added, "there are plenty of physicians whose lives are models of happiness"; so he advised the girl to go ahead with her rash project of marrying a doctor, and to hope for the best. But—possibly to give her courage—he pointed out "five reasons why so many doctors' marriages end on the rocks:"

1. "The husband is away from home too much . . .

2. "He often works under great strain and may be less patient and helpful than he should be.

3. "Even when he is home, his mind will be elsewhere. Physicians' wives have often complained of this to me. 'I'm telling my husband something,' one will say, 'and I think he's listening; but suddenly I find he's thinking about whether he can save old Mr. X's life and doesn't even hear me.'

4. ". . . A physician deals mainly with women who can't talk back to

him, namely patients and nurses. Sometimes this leaves him unprepared to discuss things with his wife as an equal.

5. "The medical profession has the highest social prestige of any and also a good financial standing, and its members are often picked out for exploitation by unscrupulous women."

Health Plan Announces Small-Bill Coverage

Most health insurance plans emphasize protection against big bills. But New York City's Group Health Insurance, Inc., has begun featuring a plan that provides group subscribers with coverage for smaller bills, too.

Offered as a rider to the organization's basic policy (and built around that "forgotten man" of most insurance plans, the family doctor), the new insurance covers such items as office and home visits; out-of-hospital surgical care; and X-rays and laboratory procedures performed in the doctor's office.

Group Health Insurance—which is both nonprofit and open-panel—points out proudly that its subscribers have free choice of physician. Some 9,000 of the city's 18,000 M.D.s already participate in the organization's basic plan; most of them are expected to accept the rider as well.

If the patient goes to any one of the participating doctors, his bills will be paid in full under the new

Snapshots

OLD DOCTORS, it seems, don't just fade away. They keep right on practicing. In Pennsylvania, for example, 900 of 1,100 medical society members in the 65-75 age group are still on the job.

PREGNANCY NO ILLNESS: That, anyway, is the view of the Internal Revenue Service. The new tax rule, allowing deductions for sickness pay or benefits, doesn't apply to the enceinte, it says.

M.D.-SOLONS: Thirty-eight physicians these days are helping to formulate the country's laws. An American Academy of General Practice survey shows four M.D.s in the lower house of Congress, thirty-four in state legislatures.

MOM REARS HEALTH TEAM: Among the thirteen offspring of Mrs. S. L. Rucker, Virginia's Mother of 1955, are two physicians, two dentists, two nurses, and a pharmacist.

CANADIAN G.P.s have now followed the example of their U.S. colleagues by setting up a college of general practice. Also new in Canada: a commission on hospital accreditation.

plan, according to a relatively generous fee schedule. And if he goes to a nonparticipating physician, at least part of his expenses will be covered on an indemnity basis.

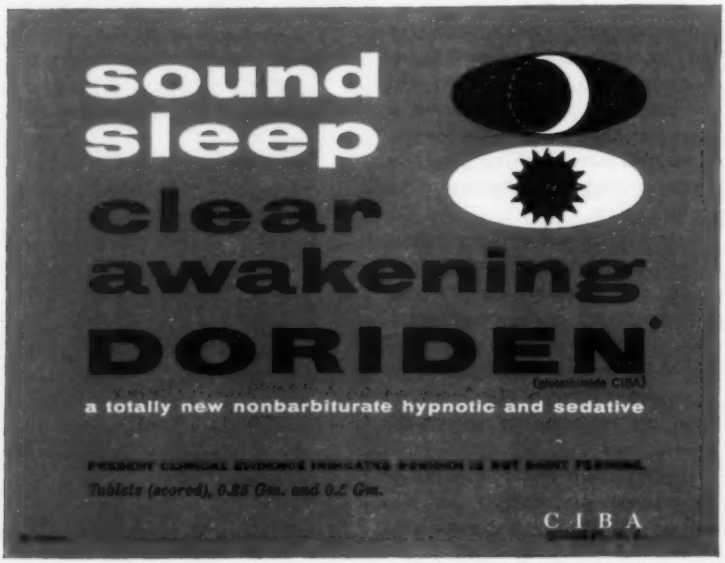
The cost of the additional coverage, while not cheap, isn't prohibitive: $2.25 a month for an individual; $6.50 for a family group.

Rx Speed-Up

A pharmacy in Alhambra, Calif., is trying out a new device for speeding up its service: a Western Union facsimile system that allows local physicians to transmit their prescription orders electronically.

By using the system—currently available to all doctors in the Alhambra area—the physician can reportedly help the druggist save the patient's waiting time. For the prescription is filled and ready to be taken home when called for. (Or, if the patient wants home delivery, the doctor has only to indicate this fact on the order.)

The facsimile device operates quite simply. The doctor writes the prescription on a specially designed blank and hands it to his nurse. She places it on the cylinder of the office facsimile transmitter (which the pharmacy will install at no cost) and presses a button. An electronic eye in the machine scans the blank and instantly flashes the Rx to a

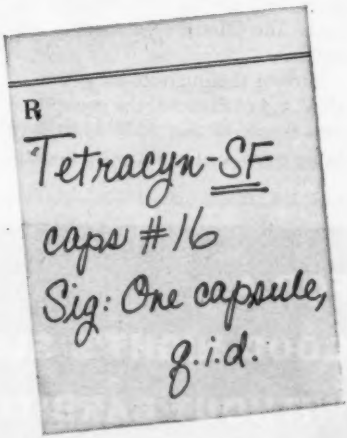


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Niacinamide	100 mg.	Menadione	
Pyridoxine hydrochloride	2 mg.	(vitamin K analog)	2 mg.

*Trademark

Pfizer

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N.Y.

similar machine in the pharmacy, where it appears as a "picture" of the original.

Older V.A. Hospitals Called Outmoded

The Veterans Administration has been so busy building new hospitals that it has permitted its old ones to languish. Fifty-six of the nation's 172 V.A. hospitals are badly in need of "major modernization," reports the House Veterans Committee.

After a thorough investigation of all V.A. installations, the committee says it would cost $150 million to bring outmoded facilities up to date. (Some $9 million is apparently needed for fire prevention and safety measures alone.)

But it's doubtful whether all this money will be forthcoming. Some observers believe that if Congress decides to go along with the Hoover Commission report, it may close some of the more antiquated buildings rather than throw good money after bad.

Heavier Penalty Sought For Fake Doctors

In most states, M.D.- impersonators get relatively light sentences: a few months in jail and/or a fine. But does the man who practices medi-

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**Chick, H.: Nutrition 7:59, 1953; Cotereau, H. et al.: Nature 161:557, 1948. Jolliffe, N. et al.: Clinical Nutrition; Hoeber, New York, 1950; pp. 586-601.*

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cine without a license deserve such leniency? Some Wisconsin lawmakers don't think so.

In fact, they've been pushing a bill that would (1) make medical practice without a license a felony rather than a misdemeanor; and (2) set the penalty at one to five years in jail for the first offense, ten to twenty for the second, and life imprisonment for the third.

The impetus for the bill isn't hard to find. Shortly before it was introduced, the authorities caught up with a Milwaukee man who had been hoodwinking the public for two years, first as an assistant to a bona fide M. D. and then as an independent practitioner. His negligible sentence (which he immediately appealed): a year in the house of correction.

Gadfly Bites Basking Polio Foundation

Spotlights focusing on the Salk vaccine this spring have accidentally revealed a sideline scufflle in Richmond, Va. The row started, apparently, because some local doctors didn't relish being treated like small potatoes by big national outfits—not even by so benevolent an outfit as the National Foundation for Infantile Paralysis.

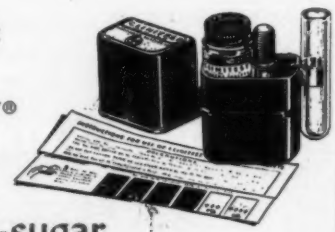
Last March, the foundation jubilantly announced plans for mass

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*Barach, J. H.; Duncan, G. G.; Joslin, E. P., and Root, H. F.: Diabetes Mellitus, in Conn, H. F.: Current Therapy 1954, W. B. Saunders Company, Philadelphia, 1954, p. 368.

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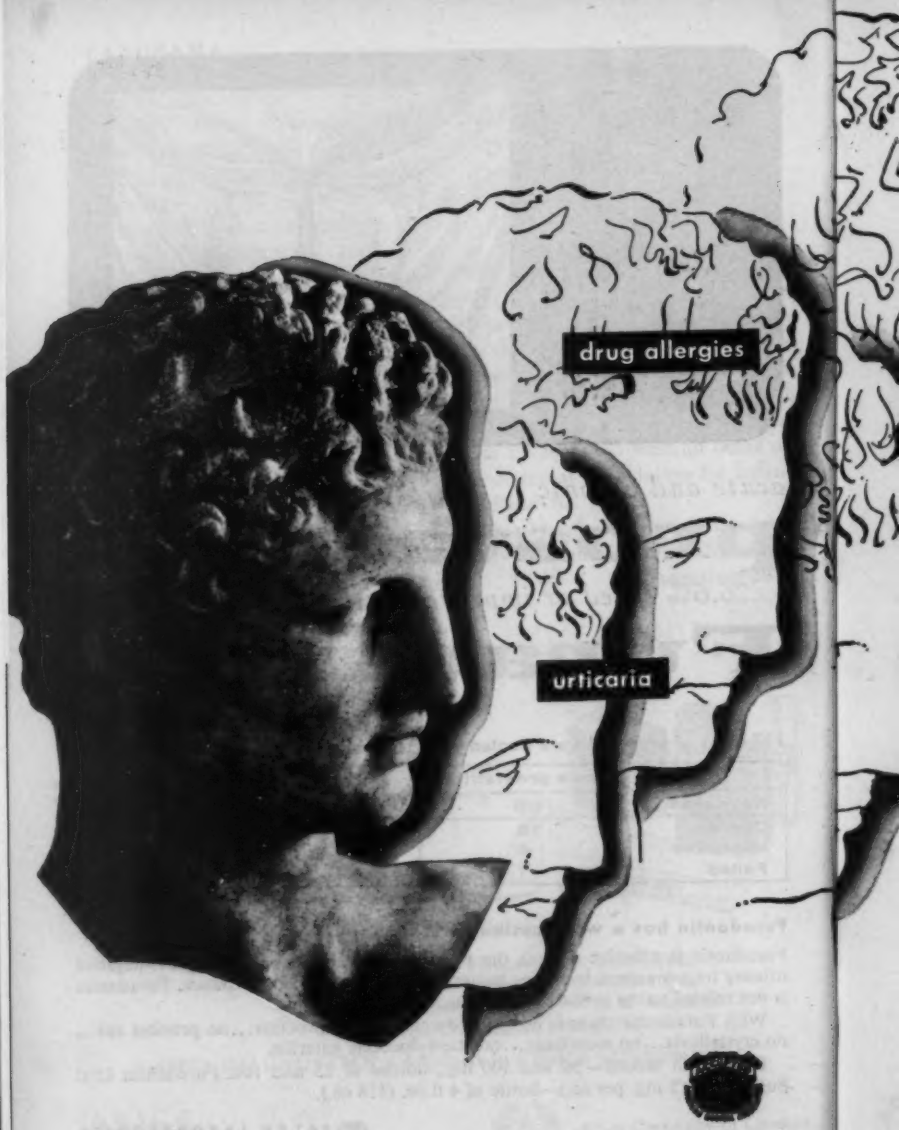
With Furadantin there is no blood dyscrasia...no proctitis...no pruritus ani... no crystalluria...no moniliasis...no staphylococcic enteritis.

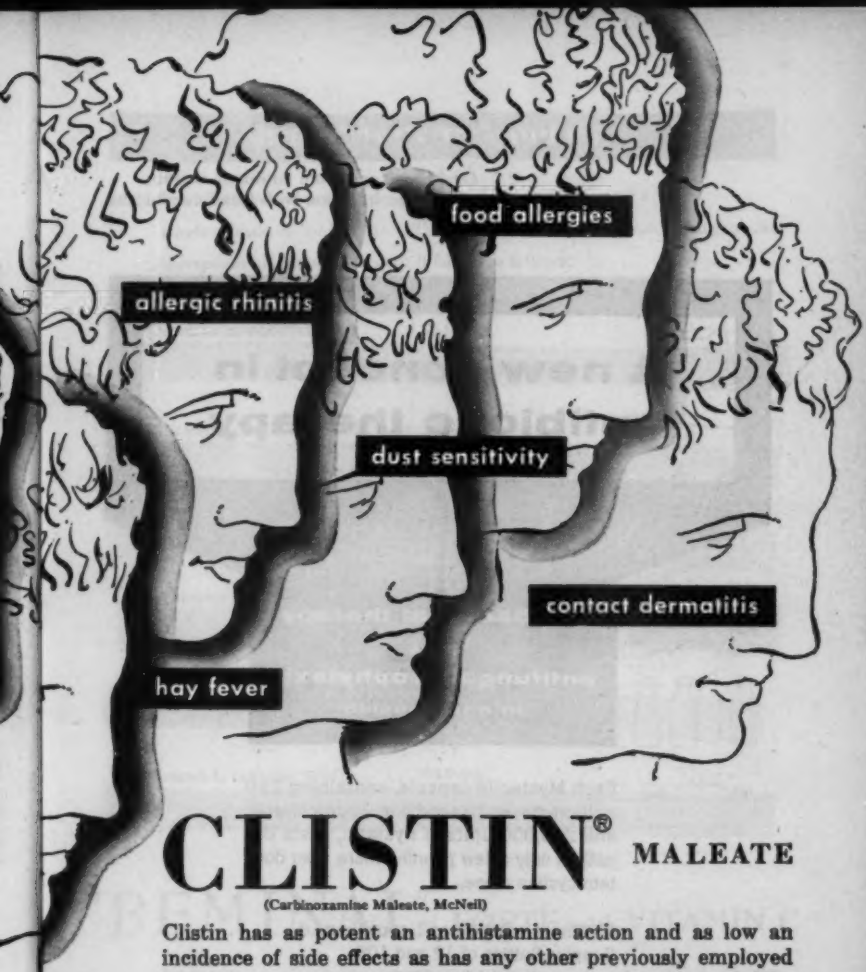
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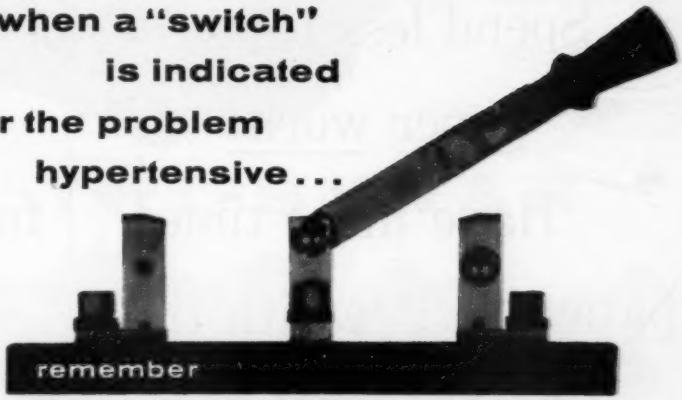
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TRI-SYNAR



Tri-Synar—predominantly a parasympathetic sedative—combines anticholinergic, antihistaminic and direct musculotropic action for better control of spasm.

Tri-Synar works like this:

Drugs in Tri-Synar ⟶	*Produce these effects* ⟶
Belladonna	Excellent anticholinergic effect Antihistaminic effect
Phenyltoloxamine	Excellent antihistaminic effect Low toxicity (drowsiness remarkably rare) Atropine-like effect
Ethaverine	Musculotropic effect Excellent inhibition of smooth muscle spasm of gastrointestinal and biliary tracts Atropine-like effect Free of addicting properties

Triple synergism produces excellent belladonna effect with fractional doses of belladonna and minimal side actions

Each Tri-Synar tablet contains:

Powdered Extract of Belladonna*	4.1 mg.
Phenyltoloxamine Dihydrogen Citrate	30.0 mg.
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1 tablet t.i.d. or q.i.d.; in more severe cases, 2 tablets t.i.d.

*The amount of belladonna is equivalent to 0.3 milligram of tincture of belladonna.

Bottles of 100

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After Use of Riasol

Deep Action

RIASOL in PSORIASIS

The essential histopathological lesion of psoriasis[1] is *acanthosis* or hypertrophy of the prickle-cells in the stratum mucosum of the epidermis. To be effective, the medication must actually go down to this deep layer.

"It is questionable if any of the common bases used in ointments (*e.g.*, fixed oils, fats, lanolin or petrolatum) facilitate the absorption through the normal skin of drugs incorporated in them," writes Grollman[2].

The base of RIASOL is a saponaceous vehicle which carries the alterative, *mercury*, direct to the prickle-cell lesions. This is one reason why RIASOL improved the skin patches of psoriasis in 76% cases and eradicated the lesions in 38%.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin, invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

RIASOL is supplied in 4 and 8 fld. oz. bottles at pharmacies or direct.

[1]Vickers, H.R., in *Psoriasis*, in *Modern Practice in Dermatology*, 1950, pp. 241-50.

[2]Grollman, A., *Pharmacology and Therapeutics*, 1954, p. 558.

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Dramatically simple automation of radiographic control which, even in unskilled hands, closely approaches the goal of "a good picture every time."

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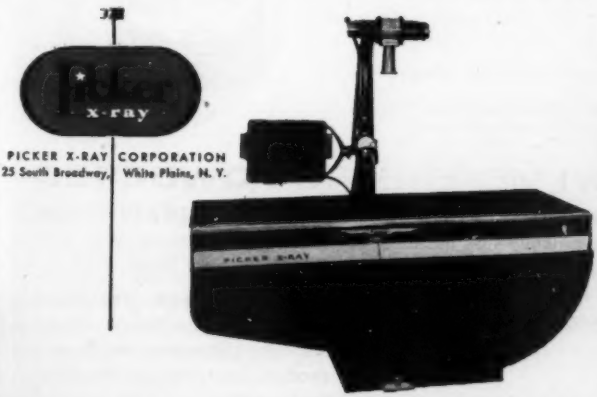
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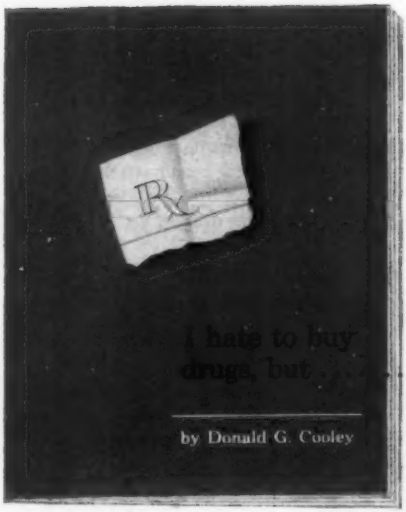
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. . . These words almost express a prevalent attitude – but not quite. Most people hate to buy drugs, *period.*

Donald G. Cooley is an exception. He, too, hates to buy drugs, BUT...he knows that the incidence and severity of illness have been dramatically reduced by the hundreds of fine drugs resulting from the pharmaceutical industry's research efforts.

In a new booklet, "I hate to buy drugs, BUT...", Mr. Cooley shows a clear understanding of the question of drug prices and why drugs are "diamond-studded bargains."

But, do your patients understand...why prescriptions for new drugs may be *initially* high-priced?...how

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natural competition, as with penicillin for example, results in considerably lower drug prices?...that $5 worth of capsules may prevent hundreds of dollars in surgical and hospital fees? Most doctors and those serving the medical profession understand these things. *But how about your patients?*

Your waiting room is a logical place for Mr. Cooley's booklet. The interest of all concerned—doctor, pharmacist, manufacturer, *and the public*—will best be served by frank, factual information about the cost of drugs.

A limited supply of booklets is available for you—upon request—from the National Pharmaceutical Council, 610 Fifth Avenue, New York 20, N. Y. "I hate to buy drugs, but..." may go a long way toward clearing some misconceptions. Why not write today, on your letterhead or prescription pad, for a supply? Be sure to specify the quantity.

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The more brands of filter cigarettes that are introduced—the more innovations in filtering—the clearer becomes the difference in KENT. Consider for a moment why.

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Indeed, the material in KENT's Micronite Filter is the choice in *many* places where filter requirements are most exacting . . . where filters *have* to work.

With such filtering efficiency, it is understandable why KENT with the Micronite Filter takes out even microscopic particles—why KENT is *proved* effective in impartial scientific test after test.

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May we suggest you evaluate KENT for yourself, doctor? We firmly believe that, with the first carton, you will reach the same conclusion. As always, there is a difference in KENT. And now more than ever before.



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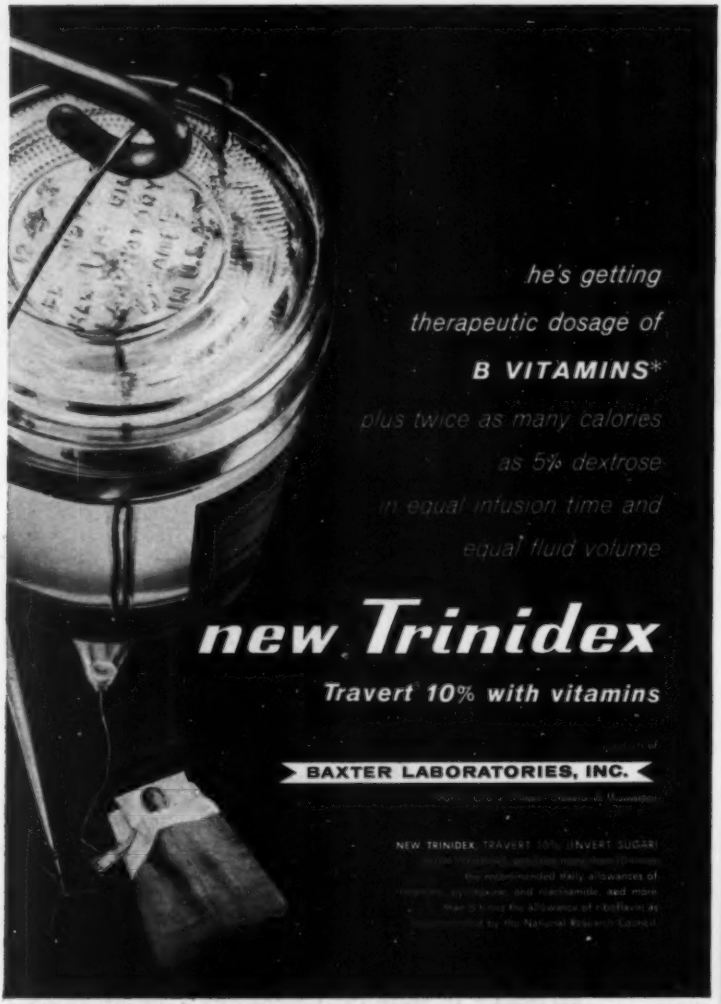
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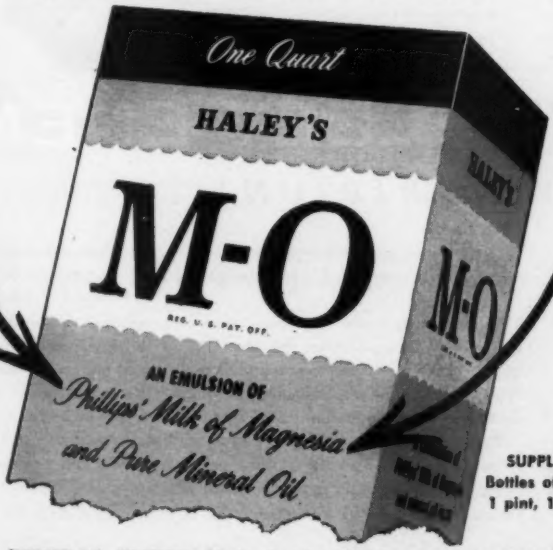
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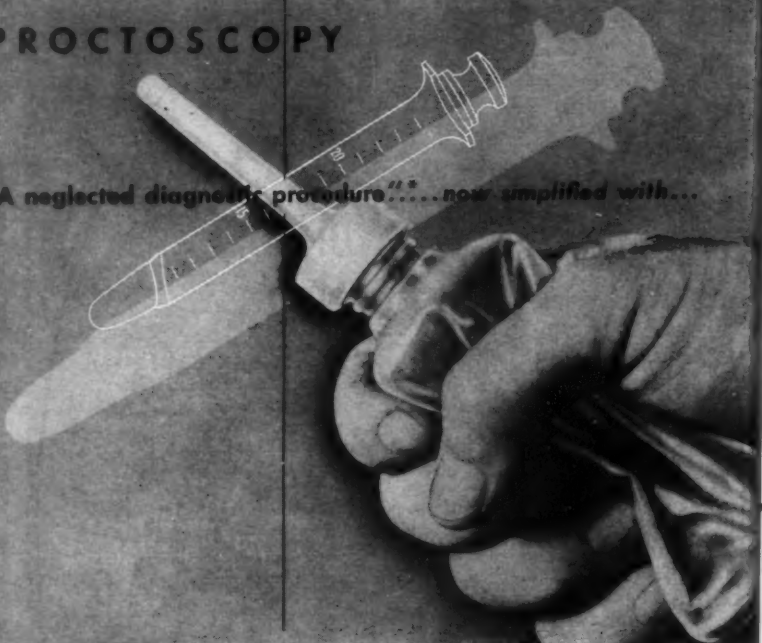


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Bottles of 8 oz., 1 pint, 1 quart.

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"A neglected diagnostic procedure"*.....now simplified with...



THE FLEET ENEMA

DISPOSABLE UNIT

"'Probably no other office procedure except blood pressure determination in the adult gives as high a percentage of positive diagnostic information.'"
— *N. La. St. Med. Soc. 104:356, Sept. '54.*

It is now a simple matter to prepare patients for proctoscopic or sigmoidoscopic examination during an office visit. The Fleet Enema Disposable Unit is superior in cleansing effect to a tap water or saline enema of one or two pints and less irritating than a soap suds enema. Thorough left colon catharsis, with minimal discomfort to the patient, is usually a matter of only four or five minutes.

Each 4½ fl. oz. disposable "squeeze bottle" contains, per 100 cc., 16 gm. sodium biphosphate and 6 gm. sodium phosphate . . . an enema solution of Phospho-Soda (Fleet) . . . gentle, prompt, thorough.

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for the "problem" patient . . .



To establish a more cooperative attitude in the "problem" patient . . . to relieve anxiety and irritability . . . to overcome confusion and depression . . . to produce a "normal" feeling of tranquility, optimism and well-being, prescribe:

Dexamyl* *tablets • elixir • Spansule† capsules*

Each 'Dexamyl' Tablet or teaspoonful (5 cc.) of the Elixir contains Dexedrine* Sulfate (dextro-amphetamine sulfate, S.K.F.), 5 mg.; and amobarbital, ½ gr. Each 'Dexamyl' *Spansule* No. 1 slowly releases the equivalent of *two* tablets; each 'Dexamyl' *Spansule* No. 2 slowly releases the equivalent of *three* tablets.

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.
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These patients must conquer "diet fear"

Very few patients, particularly the obese, are able to diet successfully because they fear that the road they must travel to lose weight is an uphill struggle. Obocell eliminates "diet fear."

Obocell makes dieting easy because it curbs the appetite and suppresses "between-meal hunger." Nicel* and d-Amphetamine in Obocell work together to provide quick and sustained control of both hunger and appetite.













Obocell

doubles the power to resist food

Each Obocell tablet supplies:
d-Amphetamine Phosphate (dibasic) .....5 mg.
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*Irwin-Neisler's brand of specially prepared high viscosity methylcellulose.
Bottles of 100, 500, 1000.



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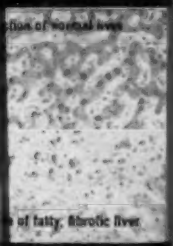
in the dangerously overweight...

protect the liver too!

Grossly obese patients and those with a history of long-standing obesity invariably suffer from impairment of liver function.[1]

Obocell Complex does more than help the patient lose weight... It supplies the needed protection for the liver, plus essential vitamins to support an overtaxed enzyme system in these special obese patients.

1. Zelman, S.: Arch. Int. Med. 50: 141, 1932.



1 capsule with a full glass of water an hour before meals. If additional appetite suppressing effect is needed, increase the morning and noon doses.

Each Obocell Complex capsule supplies:

d-Amphetamine Phosphate (dibasic)	5 mg.
Nicel*	100 mg.
Choline Bitartrate	200 mg.
Inositol	60 mg.
Thiamine Mononitrate	0.8 mg.
Riboflavin	1.2 mg.
Niacinamide	8 mg.

*Irwin-Neisler's brand of specially prepared high viscosity methylcellulose.

Bottles of 50 and 500.

Obocell® Complex

triple protection for the heavily obese patient

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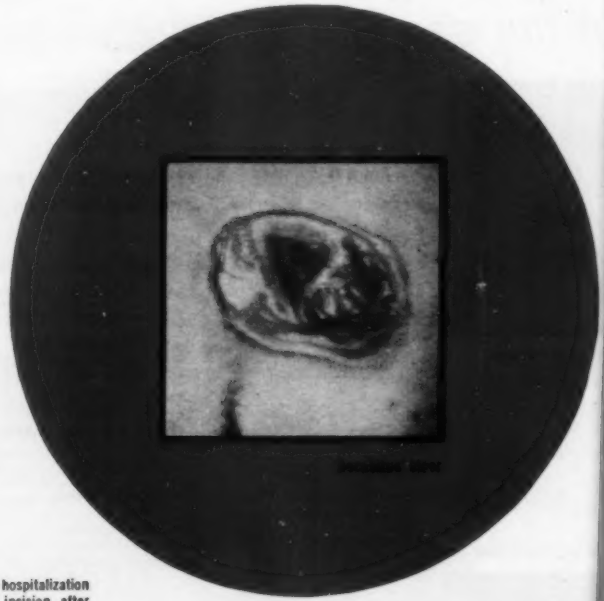
TREAT this difficult condition with

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Intramuscular trypsin

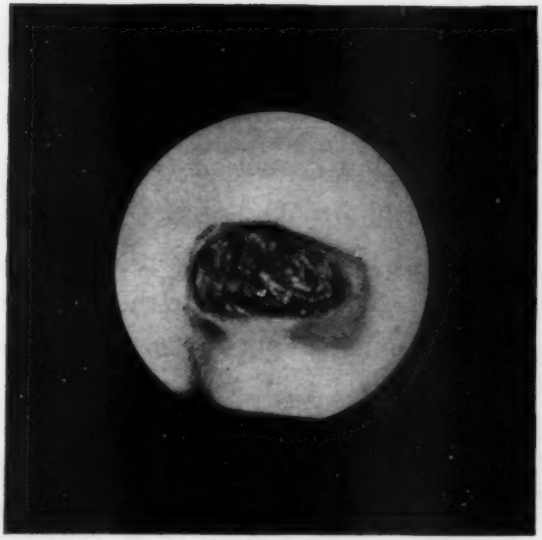
to control inflammation in a wide range of vascular and traumatic conditions • to restore local circulation



BEFORE:

Patient, 78; lengthy hospitalization from slow-healing incision after prostatectomy. Decubitus ulcer developed during 6th week. Usual therapeutic measures failed.

Safe • Not an anticoagulant



AFTER:

Parenzyme Intramuscular Trypsin, intragluteally (2.5 mg. q. 6 h.) 4 days; then twice daily. Exudate disappeared in 72 hours; granulation and friability became evident; healing rapid thereafter. Patient ambulatory in 2 weeks.

TIME BETWEEN PHOTOS: 3 WEEKS

OBTAIN striking improvement...

OTHER INDICATIONS:

Skin ulcers
decubitus
diabetic
varicose

Traumatic wounds
slow-healing wounds
bruises, contusions
black eyes

Vascular disorders
phlebitis
thrombophlebitis
phlebothrombosis

Ophthalmic disorders
iritis
iridocyclitis
chorioretinitis

IMPORTANT CLINICAL REPORTS:

Innerfield, I., *Trypsin Given Intramuscularly in Chronic, Recurrent Thrombophlebitis, J.A.M.A.*, 156:1056-1058 (Nov. 13) 1954.

Golden, H., *Intramuscular Trypsin, Its Effect in 83 Patients with Acute Inflammatory Disorders, Del. State Med. J.*, 26:267-270 (Oct.) 1954.

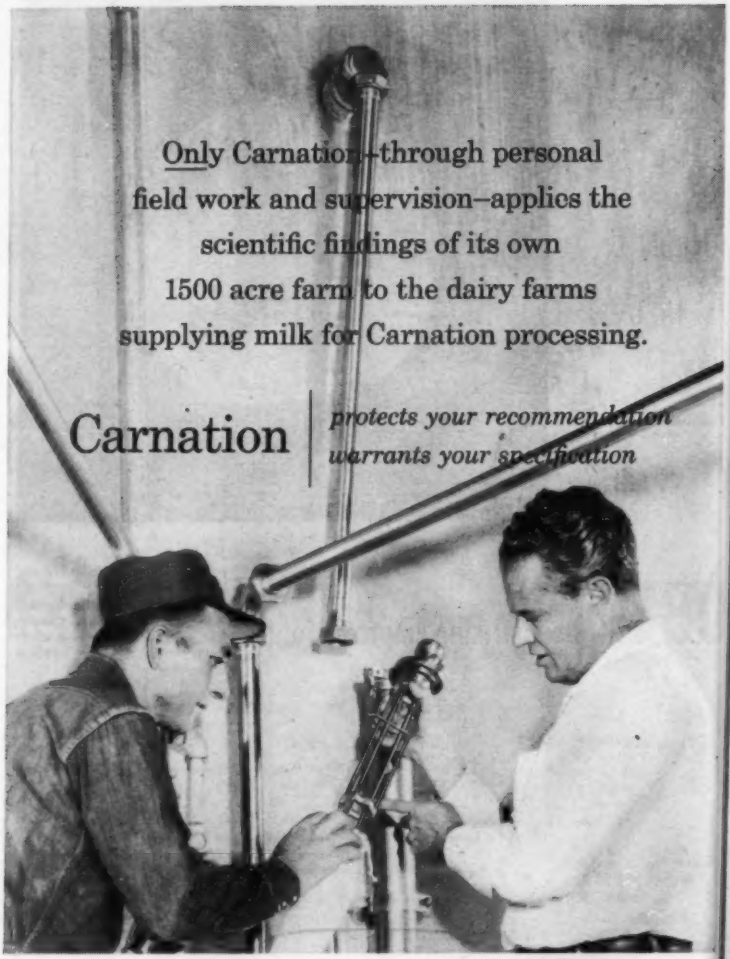
Additional clinical information on request.

DOSAGE: 2.5 mg. (0.5 cc.) intragluteally q. 6 h. until improvement results; q. 12 h. thereafter.

5-cc. multiple-dose vials (5 mg. trypsin/cc.)

The National Drug Company, Philadelphia 44, Pa.

ulant compatible with antibiotics and other therapy



Doctor, may we have your support for



She came for a check-up . . .

treat her acne, too



When a teen-ager comes to you for any reason—such as a check-up before going to camp or beginning another school term—treat that acne, too. She may be too self-conscious to ask your advice, but her acne demands your skilled supervision. Under your guidance, she can be spared the scarring of skin and psyche which so often follows improper self-medication or no medication at all.

Remember 'Acnomel' when you treat acne. 'Acnomel'—resorcinol, sulfur, and hexachlorophene, in a special grease-free vehicle—brings rapid improvement in acne, often in a few days. Moreover, 'Acnomel' quickly lifts your patient's morale: its flesh-tinted base masks unsightly acne lesions and is virtually invisible when applied.

ACNOMEL* CREAM

(Also available: 'Acnomel' Cake)

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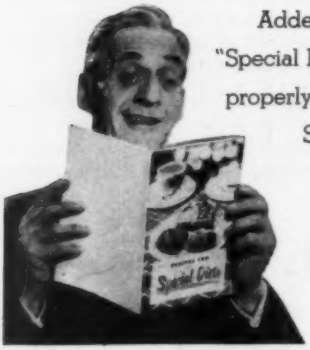
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When your geriatric patient turns his back on food . . .



chances are his menus lack the variety and appetite appeal that make for mealtime enjoyment. Gerber can help you here. For Gerber offers a wide variety of Strained and Junior (minced) Foods to give you greater prescription selectivity—make substitutions for "finicky" eaters possible. 4 cereals, over 60 fruits, vegetables, meats, soups, desserts, processed to preserve true flavors, appealing colors, a high degree of wholesome food values.

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Rapid specific action in
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Particularly safe and effective in establishing and maintaining
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Usual Dose: 1 tablet t.i.d. 1 hr. a.c.

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WITH RAUWOLFIA COMPOUND

Hypotensive
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in mild to severe
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70 Ship Street • Providence 2, R. I.

1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
2. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery 18:512, 1949.
4. Turell, R.: New York St. J. M. 50:2282, 1950.

Letters

Says clergymen prefer to pay • In favor of dispensing • Why young men choose medicine as a career • Medical 'soap operas' • Should doctors use small claims courts? • Bills in plain envelopes

Hospital Parking

SIRS: I think I can suggest an approach to the problem of parking near hospitals:

Let each physician who has trouble of this kind earmark all future donations to his hospital for the express purpose of improving parking facilities.

Solomon Garb, M.D.
Yonkers, N.Y.

About Referrals

SIRS: Dr. Henry A. Davidson's article, "How to Handle Referrals," is an excellent one and should do a great deal of good for the profession. But there is one point in it on which I violently disagree: that is, the quibbling over choice of consultant.

If a patient comes to my office, I assume that he has confidence in my ability and integrity. He also, by inference, expects me to see that he gets proper care when I am unwilling or not sufficiently qualified to handle his case. So I pick his consultant for him. To do otherwise would be a betrayal of his trust.

I would not allow a patient a choice about taking a quack medicine or nostrum. Neither would I allow him to pick a consultant of whom I didn't approve.

When advice is necessary, *I* tell *him* where I want to get it. He's not likely to suspect favoritism or "old school tie" if he trusted me enough to come to me originally.

Anyway, if he doesn't like my handling of the matter, he can always discharge me . . .

Charles L. Farrell, M.D.
Pawtucket, R.I.

SIRS: . . . The Principles of Medical Ethics say, "When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation." If this rule were followed, there would be no reason for the present conflict between general practitioners and specialists.

Both the patient's physician and the consultant should tell the patient

of the probable costs and procedures in consultations. Failure to do this is the cause of a great amount of conflict among all parties concerned . . .

Dr. Davidson mentions a patient who wasn't told to take a laxative before going to a proctologist, and another who ate a full breakfast before a scheduled BMR. Here, the G.P. was at fault. It's his responsibility, not the specialist's, to impart such necessary information . . .

George A. Woodhouse, M.D.*
Pleasant Hill, Ohio

Taxpayer

SIRS: Too often we take for granted the good things that come to us and fail to thank those who are responsible for them. So, before I forget, let me thank you profoundly and sincerely for the great help that MEDICAL ECONOMICS rendered in its March, 1955, issue to those taxpayers like myself who had to fill out their Federal returns.

The samples you published, so clearly filled out, were of immeasurable help to me. I do hope you will repeat this same service in the years to come. I truly appreciated it.

Walter W. Kistler, M.D.
Wilkes-Barre, Pa.

Fees for the Clergy

SIRS: Like most of the clergymen quoted in your recent report of Dr. Carl B. Alden's survey, I prefer to pay *something* for medical care. It hurts a pastor's self-respect to accept charity, no matter how kindly the spirit in which it is given—especially when that charity is not strictly necessary.

The economic situation of the average clergyman has changed considerably since the days when a large part of his income came from donations of goods and services. The salaries that churches pay have been rising steadily for the past twenty years. They may not always have kept up with inflationary trends. But pastors can generally afford to pay their doctors, except in unusual cases . . .

In my humble opinion, it will be a wholesome thing for both professions when clergymen assist in the support of physicians, just as many physicians now assist in the support of the clergy.

Wouter Van Garrett
Ocean City, N.J.

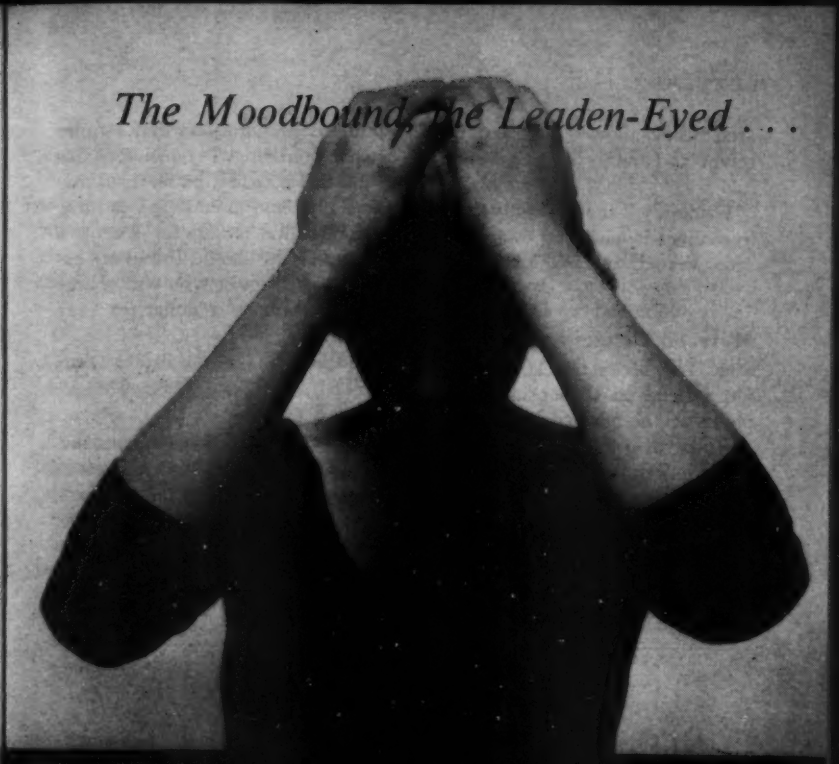
'Medical Democracy'

SIRS: Someone signing himself "Medical Democracy" is apparently sending postcards to newspapers all over the country. The one I saw went like this:

"Why don't we allow people to buy what they want to at drugstores and treat themselves? *Isn't this democratic?* Why is all medical knowledge so carefully guarded from the people? Why aren't people taught practical physiology and practical medicine from the fourth grade up through college? Why

*Dr. Woodhouse is a member of the Judicial Council of the American Medical Association.

The Moodbound, the Leaden-Eyed . . .



These are the patients dulled by mild depression — the listless, lagging, defeated, cheerless. For them Oral WYAMINE offers smooth, gentle stimulation to banish the jaded, arid outlook, to revive mettle and resolution. In therapeutic doses, Oral WYAMINE elevates the mood with little risk of amphetamine-like side-effects. For lasting lift without post-therapy depression, hyperexcitation, or disturbance in appetite.

Dosage: May range from 6.25 to 50 mg. daily, taken in 1 or 2 doses. Many patients experience a diurnal variation in mood—marked by morning depression. Under such circumstances, a single dose in the morning is often sufficient.

Supplied: Tablets, 25 mg. (scored), vials of 24 and bottles of 100; also, 12.5 mg. (scored), bottles of 100. Elixir, 25 mg. per 5-cc. teaspoonful, bottles of 1 pint.

Wyeth

Philadelphia 1, Pa.

NEW WYAMINE SULFATE

MEPHENTERMINE SULFATE

Mood Amelioration without Excitation

aren't they allowed to treat themselves and family if they want to? . . ."

Evidently the "do-it-yourself" movement is marching on.

Frederick C. Waldbillig, M.D.
Burnt Hills, N.Y.

More on Druggists

SIRS: Your recent article, "Druggists Draw Bead on Dispensing M.D.s," points up the narrow-minded prejudices of a group that consistently and vociferously demands the welfare of their small minority at the expense of the general public.

I am now completing a year's G.P. residency. I plan to practice in a small community and to dispense standard preparations that require no compounding. I conceive of this as a service to my patients—saving them time and money. If I can buy phenobarbital tablets for 7 cents a hundred, why should I send my patient to a druggist who will charge him 50 cents to a dollar, or even more? . . .

Tom Brewer, M.D.
Independence, La.

SIRS: . . . As your article mentioned, many general practitioners practice twenty to twenty-five miles from a drugstore. Are sick people or their families expected to travel that distance for medicine? Sometimes the time factor is important . . .



In the city where I practice, the drugstores close at 1 P.M. Sundays, 9 P.M. weekdays. If a person becomes ill after those hours and needs medicine, what is he going to do? Wait till the drugstore opens at 8:30 the next morning? . . .

M.D., New Hampshire

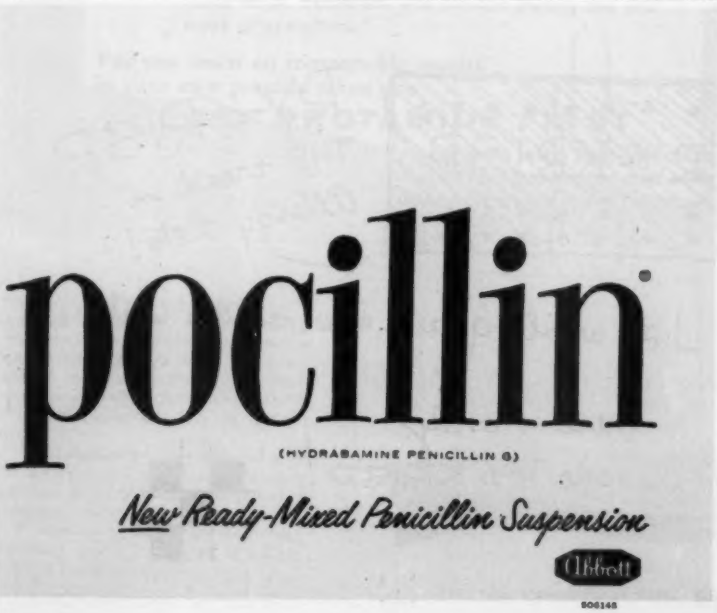
SIRS: . . . Besides the prescribing druggist, another evil is the salesman who calls on farmers to sell groceries and nostrums for any and all ailments. One such salesman was asked by a patient of mine what she should use for a sore mouth. He prescribed Bag Balm, which, I am told, is used to treat mastitis in cows. Apparently it helped her, where both the dentist and I had failed. So now I guess she will patronize a veterinarian regularly.

M.D., Illinois

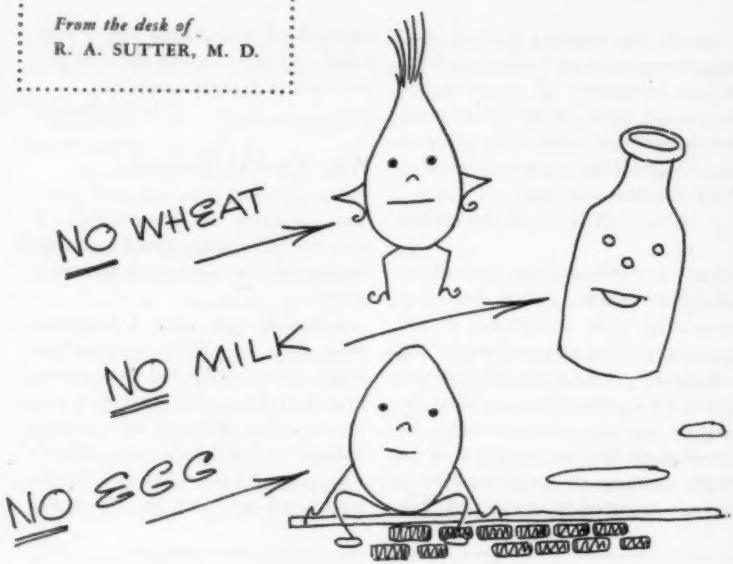
Why They're Doctors

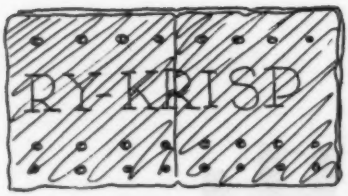
SIRS: . . . Forty years ago, as a part-time assistant in bacteriology, I used to ask each member of my classes why he was taking up medicine.

I usually got what I regarded then as a very silly explanation: From early childhood the young man had heard his parents (particularly his mother) tell visiting friends or family that her Johnny was going to be a doctor. Or he might tell me that his playmates



From the desk of
R. A. SUTTER, M. D.





RY-KRISP
THE bread in
allergy diets!

Just whole-grain rye, salt & water

There is only
one RY-KRISP!

FOR YOUR PATIENTS WITH POST-INFECTION NEURITIS

USE

PROTAMIDE

PROMPTLY

for faster,
surer recovery
without relapse

In post-infection neuritis (following upper respiratory or virus infection), one ampul of Protamide daily for five days has been shown to produce complete recovery without relapse in 85% of patients when treatment was started during the *first week of symptoms.**

You can count on comparable results in your own practice when you

USE PROTAMIDE FIRST

for patients with post-infection neuritis, herpes zoster and certain other nerve root pain problems.

Pharmacologically safe and clinically assayed, Protamide is a sterile colloidal solution prepared from animal gastric mucosa. Due to an exclusive, unique denaturing process, protein reaction cannot be demonstrated with Protamide although it is of protein origin.

The solution is straw colored with an adjusted pH of 5.9. It is virtually painless on administration and is used intramuscularly only.

Protamide is stable at room temperature and is packaged in 1.3 cc. ampuls in boxes of ten.

*Smith, R. T., New York Med. 8:16, 1952.



used to bring him their dolls to be doctored. Possibly 80 per cent gave this type of answer.

More than a few chose the career of medicine by exclusion: "Upstate farmers like my father like their sons to become professional men. My older brother is a lawyer, so I had a choice of dentistry, medicine, or the ministry. I chose medicine."

The only answer that seemed to me rational (in those days) was from a student who'd been promised a real boost by an uncle who was an ophthalmologist. (Materialistic? Maybe.)

I must admit now that in my more mature opinion it's not so silly for a young man to study medicine because of a childhood leaning to that profession. It takes an idealist to stick faithfully to the practice of medicine along ethical and humanitarian lines.

Harry A. Schatz, M.D.
Philadelphia, Pa.

TV Medicine

SIRS: I agree with Jack Gould, radio and TV critic of the New York Times, that TV's "medical jag" has gone too far. [See MEDICAL ECONOMICS, February, 1955, page 7.] Too many medical "soap operas" are being produced nowadays—and a lot of them, as Mr. Gould says, are in questionable taste.

It's wryly amusing to see our tra-

"Premarin" relieves menopausal symptoms with virtually no side effects, and imparts a highly gratifying "sense of well-being."

"Premarin"®—Conjugated Estrogens (equine)

5511

REVICAPS*

d-Amphetamine-Vitamins and Minerals Lederle



RE ducing
VI tamin
CAPS ules

ONE, TWO,
BUCKLE MY SHOE...

When obesity begins to make daily living more and more difficult, REVICAPS *Lederle* will often prove a valuable aid to successful management.

REVICAPS does three important things:

It depresses the appetite, with d-amphetamine (5 mg. per capsule) plus bulk-producing methylcellulose providing double anorexic action.

It elevates the mood, cheering the patient and making him more cooperative in following a reducing diet.

It prevents dietary deficiencies, providing the essential vitamins and minerals frequently lacking in unsupervised reducing diets.

REVICAPS is simple to prescribe, and easy for the patient to take—1 or 2 capsules, ½ to 1 hour before each meal.

Lederle

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
Pearl River, New York

*REG. U.S. PAT. OFF.

ditionally modest profession leap, with the approval of the moguls, into this orgy of self-love displayed on our newest mass medium. Doctors who wouldn't dream of allowing one another a paltry inch of newspaper advertising (unethical, don't y'know) are now parading in front of the TV cameras, to be seen by millions, in order to prove that they are finally ready to save the human race—medically, in a pinch, but preferably with the knife.

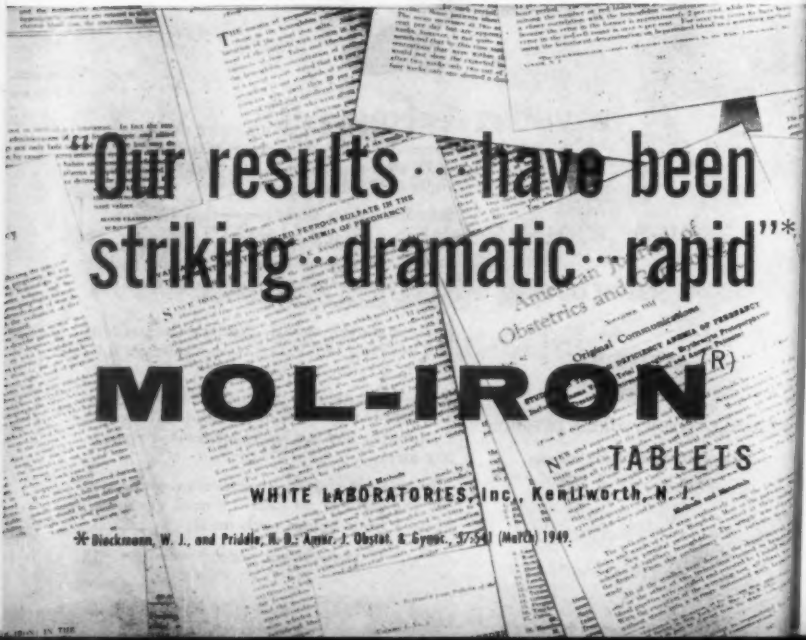
We do all this in the name of satiating the public's thirst for knowledge. But I can't help thinking we are engaging in some mighty high-powered promotion.

When a really serious fan asks, "Who was that glioblastoma multiforme I seen you with on Channel 6 last night, Doctor?" can we give him the politely but firmly raised eyebrow? Or do we, rather, owe him a full explanation on more or less equal terms?

I can't believe that people are being entertained, or even particularly edified, by post-graduate medcal education in their living rooms...

Kevin M. Cosgrove, M.D.
Rutland, Vt.

SIRS: Some of your readers recently criticized certain technical aspects of "Medic." In my opinion, such quibbling misses the point of the show entirely: namely, that it is the



To put roses in the cheeks of the pale and run-down child...



'Troph-Iron' offers the appetite-stimulating, growth-promoting activity of the potent B_{12}-B_1 Trophite† formula, plus: (1) treatment of and protection against nutritional iron deficiency; (2) a substantial increase in appetite stimulation, due to the activity of iron itself.

Each teaspoonful (5 cc.)—the recommended daily dose—of 'Troph-Iron' provides:

Vitamin B_{12}	*25 mcg.*
Vitamin B_1	*10 mg.*
Ferric pyrophosphate	*250 mg.*

Note:
'Troph-Iron' is supplied to your pharmacist in specially treated, light resistant 4 fl. oz. bottles. Please prescribe in this size.

prescribe **Troph-Iron**

Smith, Kline & French Laboratories, Philadelphia

Trademark

†T.M. Reg. U.S. Pat. Off.

the Resions

...specifics in diarrhea

The RESIONS offer two effective compounds for treatment of almost any diarrheal condition found in clinical practice.

The RESIONS act by ion exchange . . . to attract, bind and remove toxic materials in diarrheas caused by food or bacterial toxins, by prolonged use of certain drugs, and in general infectious diseases.

The RESIONS *are safe* because they are totally insoluble and non-toxic.

RESION therapy will control about 90% of common diarrheas.

RESION P-M-S is intended specifically for rapid control of those rare diarrheas caused by Gram-negative organisms; to prevent secondary bacterial infection; in mycotic diarrhea following the use of the broad-spectrum antibiotics, and to inhibit the enteric growth of *C. albicans* (Monilia).

Resion

time-tested, adsorbent effectiveness

Polyamine methylene resin	10%
Sodium aluminum silicate	10%
Magnesium aluminum silicate	1.25%



CONGO MAGIC
(Dysentery Fetish)

RESION therapy now works scientific magic against diarrhea.

and

Resion P-M-S

A new formula providing antibacterials to combat bacillary and fungal vector

NATIONAL

Each 15 cc. contains the RESION formula plus

Polymyxin-B sulfate	125,000 unit
Phthalylsulfacetamide	1.0 Gm
Para hydroxybenzoic acid esters	0.235 Gm

Dosage: RESION—1 tablespoonful hourly for 4 doses; then every 3 hours while awake. RESION P-M-S—1 tablespoonful hourly for 3 doses; then 3 times daily.

Supplied: RESION, in bottles of 4 and 12 fluid ounces. RESION P-M-S, bottles of 4 fl. oz.

THE NATIONAL DRUG COMPANY
Philadelphia 44, Pa.

best single public relations product the profession has produced to date.

The public doesn't give a tinker's damn whether this or that little procedure is absolutely sound from a scientific standpoint. People are impressed with the total impact of the show; and that impact, at least in this area, is good—very good.

The doctors of the Los Angeles County Medical Association are to be congratulated on their activity in connection with Medic. I hope they won't be overly disturbed by the criticism of colleagues whose only relationship to television is cussing when the tube blows out.

Joseph E. Palmer
Executive Secretary
Indianapolis Medical Society
Indianapolis, Ind.

Serenity

SIRS: I enjoyed and appreciated reading Dr. Alan Gregg's comments in "Real Physician—or Plain M.D.?" His mention of serenity reminded me of a little quote:

"God grant me the serenity to accept the things I can't change, the courage to change the things I can, and the wisdom to know the difference."

Theodore Bange, M.D.
Cincinnati, Ohio

No Indemnity, Please!

SIRS: Twice in the last three weeks I have tried unsuccessfully to collect from patients who are fully covered by Ohio Medical Indemnity, Inc. (Blue Shield). One of these patients was paid last August for services performed in July. I have a photostatic copy of the check with his endorsement. Yet he continually excuses himself for not paying me, on grounds that he is not working.

In many cases, this policy of assigning benefits to the patient leads to his getting the services *and* the money, too. Surely some method should be found of correcting this abuse.

Keith W. Cameron, M.B., CH. B.*
Ary, Ky.

Medical Messiahs

SIRS: I heartily endorse Dr. William S. Hitrec's views on the "public washers of the medical profession's dirty linen" . . .

We seem to have a plethora of self-appointed Messiahs who, in some unaccountable fashion, acquired medical degrees. These noble souls find too little opportunity to exhibit their unusual spiritual gifts in private practice; they must go out and redeem the multitude from the greed and incompetence of their colleagues.

If they were in any other profession, such a patronizing performance would earn them a sharp rebuke from their peers and the justified contempt of the judicious.

Away with these hypocrites and

*For readers unfamiliar with the M.B. and Ch.B. degrees, Dr. Cameron explains: "Bachelor of Medicine, Bachelor of Surgery ('Chirurgerie') is the regular degree of most English medical schools. It corresponds to the American M.D., whereas the English M.D. is . . . a purely academic, post-graduate affair."

traitors who strive to capitalize on distrust and to proclaim themselves the exclusive possessors of wisdom and nobility!

D. P. Griffin, M.D.
Bridgeport, Conn.

Colored Charge Slips

SIRS: Our seven-man group uses charge slips with receipts attached, very much like the illustration in your article on the subject. Each doctor has a different-colored slip, with his name imprinted at the top. This assures a minimum of errors in crediting him with work done . . .

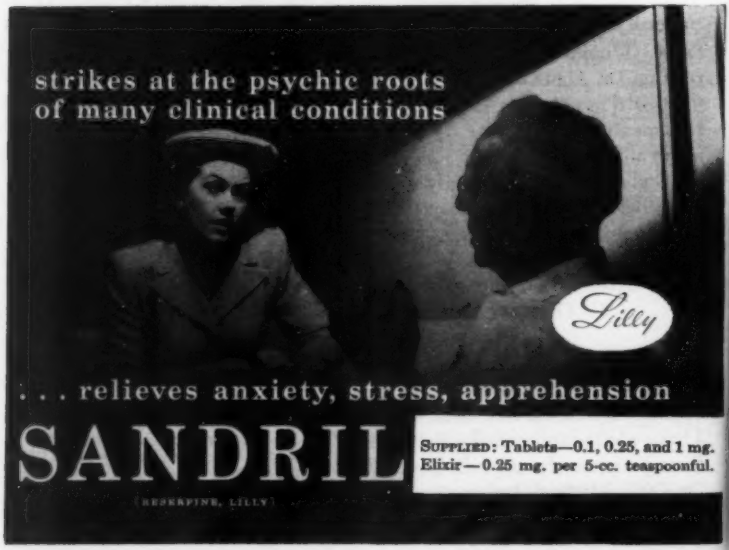
We've also found it a good idea to have an aide number each doctor's charge slips, starting with 1 for his first patient each morning. This gives us exact information on the number of patient he sees. It also prevents loss of slips, since each must be accounted for at the end of the day. And it assures patients' being seen in the order of their arrival.

Harry G. Clark, M.D.
Detroit, Mich.

Small Claims

SIRS: According to a recent article, small claims courts can sometimes help doctors collect their fees. That may be true, but we in California consider it poor public relations for the doctor to sue.

Our doctors do not like to appear



Upjohn

Gradual and sustained lowering of blood pressure:

Reserpoid

TRADEMARK FOR THE UPJOHN BRAND OF RESERPINE

(Pure crystalline alkaloid)

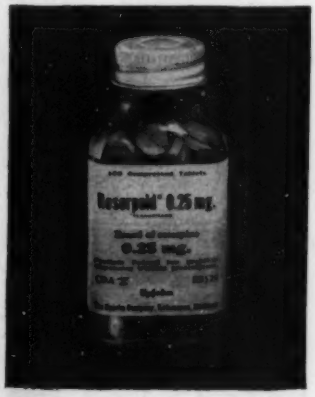
Each tablet contains:

Reserpine ..... 0.1 mg.
or 0.25 mg.
or 1.0 mg.

Supplied:

Scored tablets
0.1 and 0.25 mg. in bottles of 100 and 500
1.0 mg. in bottles of 100

The Upjohn Company, Kalamazoo, Michigan



in court. Nor do they wish to have their names appear in suing anyone for their fees. Several reasons justify this stand:

One is that court records are public property; legal items are published in some daily newspapers and in all legal journals. Another reason is that it is undignified for a doctor to be in court arguing with a debtor. In short, a suit brought by the doctor or in his name does not win friends and influence people.

. . . So we think it's better for doctors to assign their accounts to agencies that specialize in collections. Ninety-five per cent of such accounts are collected by agencies *without suit*.

When it is necessary to go to court, the suit is brought in the name of the agency (after the doctor has authorized the action). The agency, through its attorneys, appears in court. If it's necessary to prove the account, the doctor's bookkeeper testifies. The doctor himself is kept out of the picture . . .

Herbert P. Sears
Medical and Dental Finance Bureau
Bakersfield, Calif.

'In a Plain Wrapper'

SIRS: The first time a patient asked me to send my bill in a plain envelope it seemed to me a very odd request. He had a good reason, though: His wife didn't know he was coming to see me, and he didn't want my envelope to arouse her curiosity—or suspicion. [MORE▶

℞ INFORMATION
Meratran

NEW DRUG

Meratran

(ipradrin hydrochloride)

a unique central motivant for the treatment of the emotionally tired and depressed patient

subtly returns your emotionally fatigued and depressed patients to their usual level of alertness, interest and productivity...



Meratran is chemically new and clinically different. It acts upon the subcortical area of the brain. In doses easily adjusted to patient needs its onset of action is subtle -- comfortable -- prompt. Its effectiveness is prolonged.[1-3]

- no appreciable effect on blood pressure and respiration
- restores needed sense of well being
- no tolerance or drug habituation
- normal appetite undisturbed
- no jitters - no apprehension
- little or no insomnia
- wide range of safety
- no rebound letdown

an exclusive product of Merrell research

MAXIMUM SAFE ANALGESIA

(free from risk of addiction)

in whatever potency each patient may require

By facilitating the optimal analgesic medication of each patient without risk of addiction, PHENAPHEN and PHENAPHEN WITH CODEINE have proven their wide range of clinical usefulness—for cases of simple headache to many of late cancer.

True pharmacodynamic synergism enhances the therapeutic potency of each of the 4 forms available for discriminating prescription.

PHENAPHEN
— basic non-narcotic formula
Each brown and white capsule contains:
Acetylsalicylic acid (2½ gr.).....162 mg.
Phenacetin (3 gr.).....194 mg.
Phenobarbital (¼ gr.).....16.2 mg.
Hyoscyamine sulfate (1/2000 gr.)..0.031 mg.

Phenaphen No. 2
PHENAPHEN
with CODEINE PHOSPHATE ¼ GR.
Each black and yellow capsule contains:
The basic phenaphen formula plus
Codeine phosphate (¼ gr.).....16.2 mg.

Phenaphen No. 3
PHENAPHEN
with CODEINE PHOSPHATE ½ GR.
Each black and green capsule contains:
The basic phenaphen formula plus
Codeine phosphate (½ gr.).....32.4 mg.

Phenaphen No. 4
PHENAPHEN
with CODEINE PHOSPHATE 1 GR.
Each green and white capsule contains:
The basic phenaphen formula plus
Codeine phosphate (1 gr.).....64.8 mg.

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Ethical Pharmaceuticals of Merit since 1878

Phenaphen® Robins
Phenaphen® with Codeine

In iron deficiency anemias "the iron medication of choice is ferrous sulfate".[1]

And the ferrous sulfate preparation of choice with leading hematologists and in hospitals is—'Feosol'. For, unlike ordinary ferrous sulfate preparations, 'Feosol' Tablets provide ferrous sulfate in a special coating and vehicle that ensure prompt disintegration in the acid medium of the stomach and upper duodenum, where iron is best absorbed.

Each 'Feosol' Tablet contains 3 grains exsiccated ferrous sulfate, the most effective form of oral iron—equivalent to approximately 5 grains (0.3 Gm.) crystalline ferrous sulfate. Just three or four 'Feosol' Tablets daily should produce a hemoglobin rise which often averages 1% per day—and a satisfactory reticulocyte response in one week.

the standard iron therapy



1. Alt, H.L.: Anemia (Chronic Iron Deficiency), in Conn, H.F.: Current Therapy 1952, W. B. Saunders Co., p. 200.

Smith, Kline & French Laboratories, Philadelphia 1

★T.M. Reg. U.S. Pat. Off.

I found later that there are many situations where patients prefer that reports, bills, reminders, and other mail from physicians come without the telltale return address. One patient lived in a boarding house, where all mail was placed on the hall table. Since he was visiting the town's best-known venereologist, his preference for a plain envelope was understandable.

In the same way, if a doctor is well known in the community as an obstetrician, a psychiatrist, or a urologist, the outside of the envelope may reveal as much as the contents themselves to a snooping boarder or a gossipy mother-in-law.

Since I have a home-office, I can use envelopes with my street address and city, but no name. A physician in an office building could use a room number, provided the building didn't signal itself. Thus, 2145 Farragut Building might be all right, but 2145 Medical Arts Building wouldn't. (In the latter case, the street number could be used, rather than the name of the building.)

After starting to use the non-identifying envelope, I stumbled on a dividend. A patient will open a plain envelope, out of curiosity if nothing else. But if he knows that it contains a bill from his doctor he may leave it unopened.

M.D., New Jersey

END



FOR HARD, DRY STOOLS OF
Constipated Babies

Borcherdt
MALT SOUP
Extract*

A gentle laxative modifier of milk. Just 1 or 2 tablespoonfuls in day's formula softens stools, usually overnight. Safe and easy to use.

GOOD FOR GRANDMA, TOO!

For thin, under-par older patients, acts as nutritional malt laxative. Softens stools without side effects by promoting aciduric flora. Grain extractives and potassium ions contribute to the gentle laxative effect. Dose: 2 Tbs. A.M. and bedtime for several days until stools are soft, then 1 or 2 Tbs. at bedtime to maintain regularity.

* Specially processed malt extract neutralized with potassium carbonate. In 8 oz. and 16 oz. bottles.

Samples and literature on request

BORCHERDT MALT EXTRACT CO.
217 N. Wolcott Ave., Chicago 12, Ill.

FOR SUPERIOR PERFORMANCE

FOR SUPERIOR PERFORMANCE—
In Antibiotic Therapy—POLYCYCLINE
a tetracycline produced by a unique process of direct fermentation
BRISTOL LABORATORIES INC.
SYRACUSE, NEW YORK

FOR SUPERIOR PERFORMANCE IN ANTIBIOTIC THERAPY

—effective, safer, more sustained action with this newest broad-spectrum antibiotic

Your pharmacist has all dosage forms of Polycycline available for your prescription:

Polycycline—available in many dosage forms—affords significant clinical advantages in broad-spectrum antibiotic therapy:

Effective in broad range

—against Gram-positive and Gram-negative organisms, certain rickettsiae and large viruses.

Greater tolerance

—markedly lower incidence and severity of adverse side effects.

Greater solubility

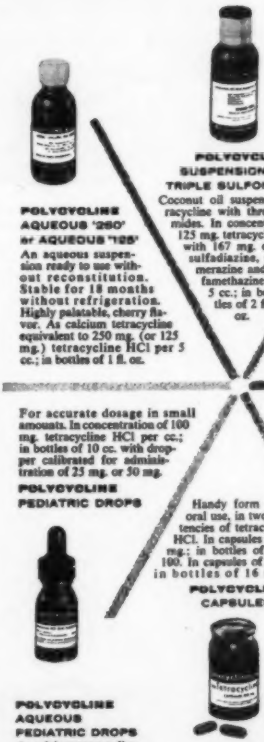
—than chlortetracycline, yielding quicker absorption and increased diffusion in body fluids and tissues.

Greater stability

—in solution than chlortetracycline or oxytetracycline, assuring higher, more sustained blood levels.

•

Polycycline is a tetracycline produced by the unique Bristol process of direct fermentation. Its basic structural formula is free of a chlorine atom (present in chlortetracycline), and of an hydroxyl group (present in oxytetracycline).



POLYCYCLINE AQUEOUS '250' or AQUEOUS '125'
An aqueous suspension ready to use without reconstitution. Stable for 18 months without refrigeration. Highly palatable, cherry flavor. As calcium tetracycline equivalent to 250 mg. (or 125 mg.) tetracycline HCl per 5 cc.; in bottles of 1 fl. oz.

POLYCYCLINE SUSPENSION WITH TRIPLE SULFONAMIDES
Coconut oil suspension of tetracycline with three sulfonamides. In concentration of 125 mg. tetracycline HCl with 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine per 5 cc.; in bottles of 2 fl. oz.

POLYCYCLINE SUSPENSION '250'
A really palatable oil suspension, requiring no dilution or reconstitution. Needs no refrigeration—stable for 18 months. In concentration of 250 mg. tetracycline HCl per 5 cc.; in bottles of 1 fl. oz.

POLYCYCLINE PEDIATRIC DROPS
For accurate dosage in small amounts. In concentration of 100 mg. tetracycline HCl per cc.; in bottles of 10 cc. with dropper calibrated for administration of 25 mg. or 50 mg.

POLYCYCLINE INTRAMUSCULAR
For deep intramuscular injection. In single-dose vials of 100 mg. tetracycline HCl per vial.

POLYCYCLINE CAPSULES
Handy form for oral use, in two potencies of tetracycline HCl. In capsules of 100 mg.: in bottles of 25 and 100. In capsules of 250 mg.: in bottles of 16 and 100.

POLYCYCLINE AQUEOUS PEDIATRIC DROPS
As calcium tetracycline equivalent to 100 mg. tetracycline HCl per cc.; in bottles of 10 cc. with dropper calibrated at 25 mg. and 50 mg.

POLYCYCLINE OINTMENT WITH 2% XYLOCAINE*
—30 mg. tetracycline HCl with 20 mg. Lidocaine (as the base), per gram.

POLYCYCLINE OPHTHALMIC OINTMENT WITH 2% XYLOCAINE*
—10 mg. tetracycline HCl with 20 mg. Lidocaine (as the base), per gram.

*Reg. U.S. Pat. Off.

When you think of Tetracycline, think of

Bristol
LABORATORIES INC.
SYRACUSE, NEW YORK

POLYCYCLINE®

(Tetracycline HCl Bristol)

HISTACOUNT

presents **THE NEWEST, MOST COMPLETE**

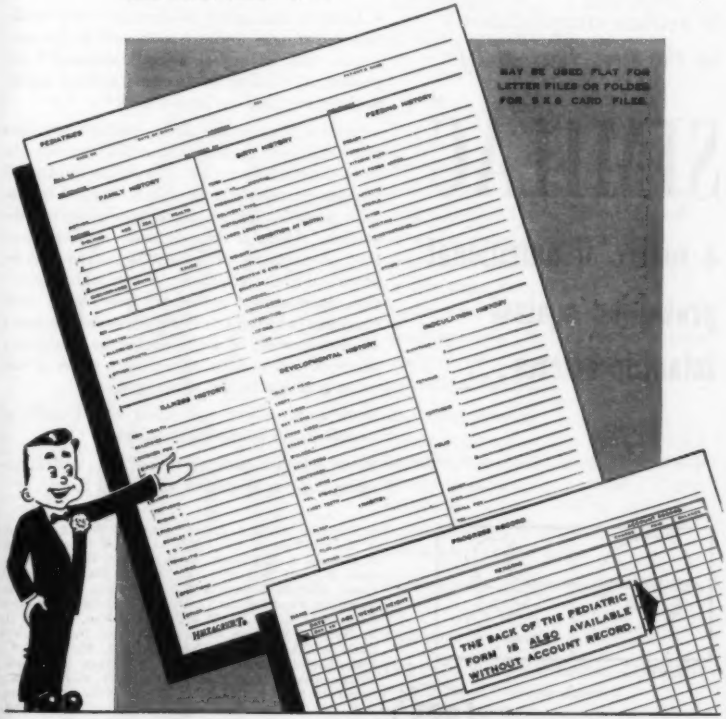
PEDIATRIC RECORD

... with POLIO inoculation chart...

... just off the press.

Write for free samples of form #300 (shown below) and our Inoculation Certificate, with POLIO provision.

PROFESSIONAL PRINTING COMPANY, INC.
NEW HYDE PARK, N. Y



America's Largest Printers to the Professions



to reduce complications in the first year of life

SIMILAC®

a source of nutritional protection against infantile eczema...

• Linoleic and other unsaturated fatty acids believed to play an important role in the prevention and therapy of infantile eczema[1-4] are present in Similac, in amounts at least equal to those reported for breast milk.[5]

• Similac, in recommended quantities, provides protein closely approximating the physiologic level supplied by breast milk.[6] The fluidity of Similac protein, comparable to that of breast milk protein, assures rapid and complete digestion.[7] There is thus virtually no likelihood that products of incomplete digestion will be absorbed to cause an allergic eczematous reaction. In contrast, customary cow's milk mixtures are believed to deliver excessive amounts of protein, some of which cannot be completely digested and may be absorbed to cause a vascular reaction in the upper corium.[8]

there is no closer equivalent to the milk of healthy, well-nourished mothers

SUPPLIED: as Powder in tins of 1 lb., with measuring cup; as Liquid in tins of 13 fl. oz.

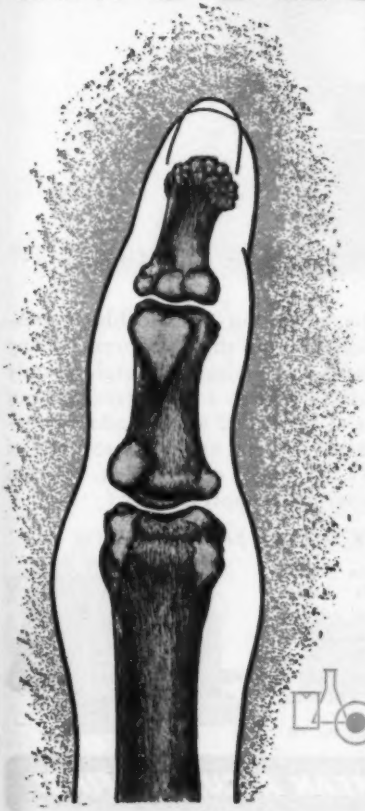


1. Editorial: J.A.M.A. *134*:606 (June 14) 1947. 2. Hansen, A. E., and Burr, G. O.: J.A.M.A. *132*:855 (Dec. 7) 1946. 3. Hansen, A. E.; Knott, E. M.; Wiese, H. F.; Shaperman, E., and McQuarrie, I.: Am. J. Dis. Child. *73*:1 (Jan.) 1947. 4. Hansen, A. E.: In, Vitamin B_6 in Human Nutrition, Report of the Tenth M & R Pediatric Research Conference, Columbus, M & R Laboratories, 1954, p. 51. 5. National Research Council: Maternal Nutrition and Child Health, Bull. 123 (Nov.) 1950. 6. Meyer, H. F.: Essentials of Infant Feeding for Physicians, Springfield, Illinois, Charles C. Thomas, 1952, p. 44. 7. Martin, C. W.: New York State J. Med. *32*:1012 (Sept.) 1932. 8. Stoesser, A.V., and Nelson, L. S.: Journal Lancet *73*:487 (Dec.) 1953.

M & R LABORATORIES, *Columbus 16, Ohio*

When there's doubt about GOUT...

Rx NEOCYLATE™ WITH COLCHICINE



Diagnosis...Therapy...
Prevention of
GOUTY ARTHRITIS

The singularly dramatic response of gouty arthritis to colchicine makes this drug a quick, effective diagnostic tool[1] as well as a choice therapeutic agent. When signs and history are absent or confusing, NEOCYLATE* with COLCHICINE resolves the doubt and simultaneously provides the immediate analgesic effect of colchicine with potentiated salicylate.

Each tablet contains:

Sodium Salicylate	0.25 Gm. (4 gr.)
p-Aminobenzoic Acid	0.25 Gm. (4 gr.)
Ascorbic Acid	20 mg. (1/3 gr.)
Colchicine	0.25 mg. (1/250 gr.)

Supplied: Bottles of 200, 500, and 1000 yellow, enteric-coated tablets.

1. Talbott, J. H.: Postgrad. Med. 5:386, May, 1949.

Literature on request

THE CENTRAL PHARMACAL COMPANY
Products Born of Continuous Research
SEYMOUR, INDIANA

*Trademark of The Central Pharmacal Co.

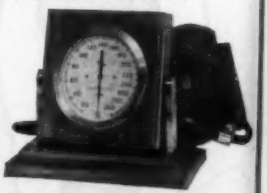
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DOCTORS in every part of the globe depend on TYCOS* blood pressure instruments. Here is the Pocket Aneroid that is accurate in any position—and it will stay that way unless it is misused. Weighing only 19 ozs., the TYCOS Sphygmomanometer fits in a small case that can be slipped into the pocket. Exclusive hook cuff fits any adult arm—slips on and off easily. It's dependable . . . you know it's accurate as long as the pointer returns to zero . . . a simple visual check. You can see this instrument at your favorite surgical supply dealer.

HERE'S ANOTHER MEMBER OF THE TAYLOR FAMILY

The new TYCOS Desk Aneroid combines Taylor accuracy with modern design. The 3⅜" ivory-tinted dial is easy to read, and the easel adjusts to any desired angle. Long pointer magnifies variations, gives maximum sensitivity. Wall model also available. Made by Taylor Instrument Companies, Rochester, N. Y., and Toronto, Canada.



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Taylor Instruments **MEAN ACCURACY FIRST**

for the "squeeze" of g.i. spasm...

when indigestion, pain, heartburn, belching, or nausea is due to g.i. spasm, MESOPIN-PB* provides the selective spasmolytic effectiveness of homatropine methylbromide (1/30 as toxic as atropine) plus the sustained sedation of phenobarbital . . . with virtual freedom from undesirable atropine effects



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Trademark

Yellow tablets and elixir containing 2.5 mg. MESOPIN* (homatropine methylbromide) and 15 mg. phenobarbital per tablet or teaspoonful. Also as MESOPIN-PB double strength in green tablets containing 5 mg. MESOPIN and 15 mg. phenobarbital. MESOPIN (without phenobarbital) is available as 2.5 mg. white tablets and green elixir, and MESOPIN double strength 5 mg. peach tablets.

[redacted]

Literature? write

ENDO PRODUCTS, Inc.
Richmond Hill 18, New York

*TRADEMARK OF ENDO PRODUCTS INC.

NEW—for weight gain—
high-calorie food supplement

MorCal*

TRADEMARK

with B_1 and B_{12}

won't be just "tolerated" by your underweights...they'll love it!

adds variety, doesn't satiate

MorCal provides a new, pleasant way to add taste-tempting variety to the weight-gain diet. It's delicious "as is," or topped with fruit and milk for breakfast or between-meal snacks. Cereal-like MorCal can be added to or mixed with almost any food on your patients' menus. This new fat preparation doesn't satiate, leaves no cloying aftertaste.

easy to use in cooking or baking

MorCal can be used as a substitute for most of the flour in cooking and baking, often increasing calorie content 30 to 100 per cent. It adds flavor as well as calories to desserts, soups, gravies, sauces, etc.

prescribe MorCal

for overactive, fast-growing youngsters, underweight adults, convalescents, the chronically ill, and elderly patients. Just two rounded tablespoonfuls four times daily (120 grams) add 720 extra calories to the diet—plus 12½ times the minimum daily requirement of vitamin B_1 and 6½ times the suggested daily supplement of vitamin B_{12}.





Request booklet for patients



Special MorCal recipe booklet

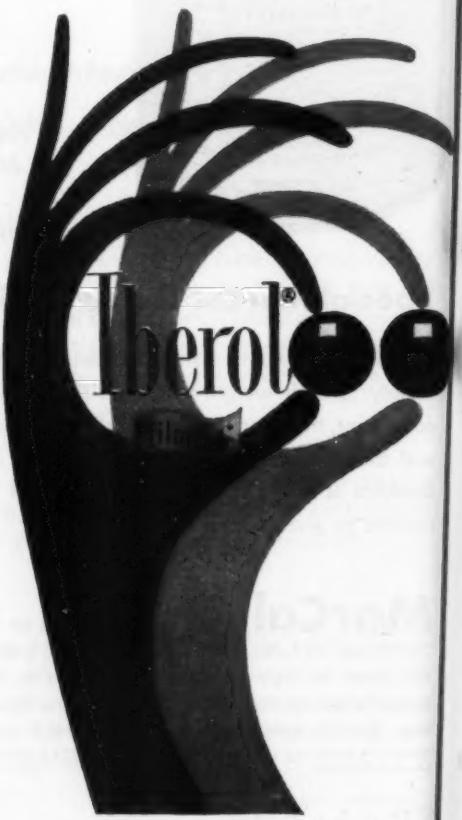
shows your patients many taste-tempting ways to add calories and variety to their weight-gain diet. Prepared by our home economics consultant, this "Recipes and Uses" booklet is enclosed above the inner seal of each one-pound tin of MorCal. A supply of these recipe booklets is yours for the asking—just let us know how many you require to give to your patients.

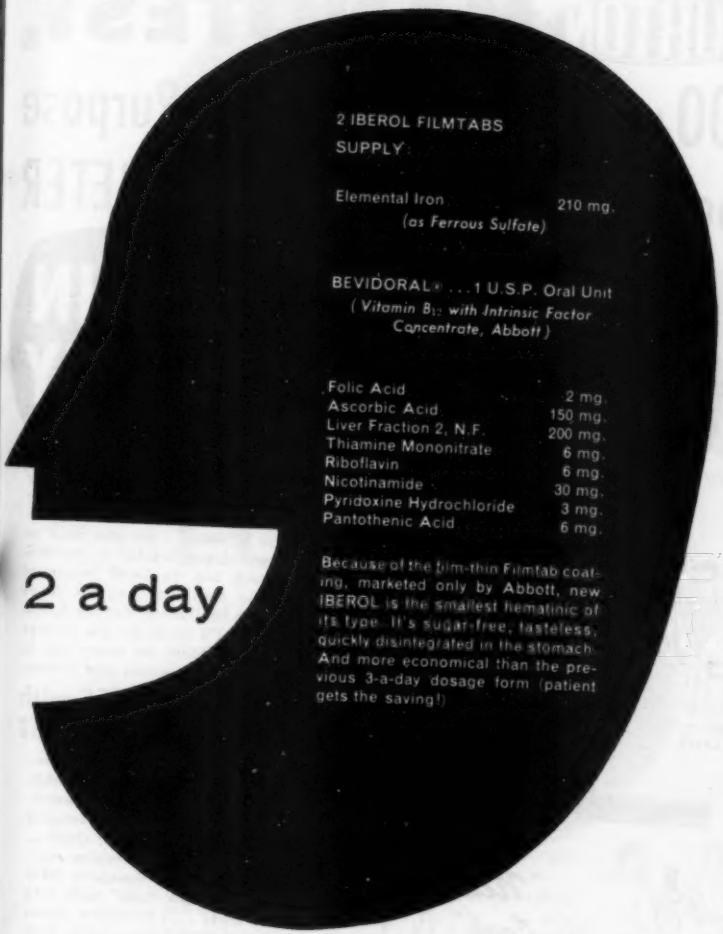
MorCal contains refined vegetable fat 44%, carbohydrate 42%, protein 9%, mineral ash 2.5%, moisture 2.5%, vitamin B_1 (thiamine mononitrate) 50 mg. per lb., and vitamin B_{12} (cyanocobalamine) 50 mcg. per lb. MorCal is prepared from hydrogenated cottonseed oil, proteins and carbohydrates from dried skim milk solids and wheat flour, natural flavorings, synthetic vitamins B_1 and B_{12}.

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COMPLETE IRON-PLUS THERAPY FOR THE ANEMIAS




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SUPPLY:
Elemental Iron 210 mg.
(as Ferrous Sulfate)
BEVIDORAL® . . . 1 U.S.P. Oral Unit
(Vitamin B12 with Intrinsic Factor Concentrate, Abbott)
Folic Acid 2 mg.
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Because of the film-thin Filmtab coating, marketed only by Abbott, new IBEROL is the smallest hematinic of its type. It's sugar-free, tasteless, quickly disintegrated in the stomach. And more economical than the previous 3-a-day dosage form (patient gets the saving!)
2 a day

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300 mm MERCURIAL All Purpose Pocket Size SPHYGMOMANOMETER







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EURAX® cream ..... lotion

(brand of crotamiton)

relief in minutes that lasts for hours

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As you know, the essential nutrients of *milk* are all-important in pregnancy . . . but total calories in whole milk sometimes create a weight problem. New *Instant* PET Nonfat Dry Milk, with all the high-quality protein, minerals and B-vitamins of whole milk—but with only half the calories—is ideal for the prenatal diet.

These concentrated nutrients can often help compensate for complications that develop in pregnancy—such as impaired digestion and low calcium absorption due to low protein intake.



The delicious fresh flavor of *Instant* PET Nonfat Dry Milk when used as a beverage, the added milk nourishment which it gives to a variety of prepared dishes and its low cost are other advantages. Try *Instant* PET Nonfat Dry Milk in the prenatal diets of your patients.

Developed by Pet Milk Company, makers of the original evaporated milk

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unexcelled among sulfa drugs . . .

for Highest Potency • Wide Spectrum
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Safety • Minimal Side Effects* • Economy

*Few therapeutic agents, and none of the other sulfas, can claim the same degree of freedom from toxic side effects offered by the Triple Sulfas. The use of only a fractional dosage of each component sulfa drug reduces the possibility of undesirable side effects to an absolute minimum. No case of agranulocytosis has been reported resulting from their use.

Because they are so well tolerated, because of their wide spectrum of effectiveness and their outstanding economy, the Council-accepted Triple Sulfas are now more widely used than any single sulfa drug.

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ASK ANY MEDICAL REPRESENTATIVE ABOUT THE TRIPLE SULFA PRODUCTS HIS COMPANY OFFERS!

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combined corticosteroid-antibiotic therapy for dermatologic conditions

. . . including poison ivy and sunburn



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SQUIBB FLUDROCORTISONE ACETATE WITH SPECTROCIN (SQUIBB NEOMYCIN-GRAMICIDIN)

the anti-inflammatory, anti-pruritic action* of FLORINEF—much more potent than that of topical hydrocortisone

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the prophylactic action* of SPECTROCIN—effective against many gram-positive and gram-negative organisms

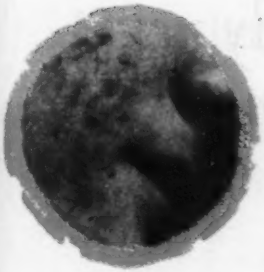
*". . . secondary infection with pustulation often follow scratching which is induced by the intense itching." Nelson, W. E.: Textbook of Pediatrics, ed. 5, Philadelphia, W. B. Saunders Company, 1950, p. 1516.

Supply: Florinef-S Lotion, 0.05 and 0.1 per cent, in 15 ml. plastic squeeze bottles. Florinef-S Ointment, 0.1 per cent, in 5 gram and 20 gram collapsible tubes.

Also available: Florinef Lotion, 0.05, 0.1 and 0.2 per cent, in 15 ml. plastic squeeze bottles. Florinef Ointment, 0.1 and 0.2 per cent, in 5 gram and 20 gram collapsible tubes.

"FLORINEF-S", "FLORINEF" AND "SPECTROCIN" ARE SQUIBB TRADEMARKS

SQUIBB



A 19 year old female with a 5 year history of cystic pustular scarring acne of face and back refractory to all other types of therapy.

After 12 weeks of treatment with "Premarin" Lotion applied to face only, remission is apparent. Untreated back remains unchanged.



Excellent results obtained in acne vulgaris with "Premarin®" Lotion

Conjugated Estrogens (equine) for topical application

The case illustrated above is typical of the response obtained with "Premarin" Lotion in 70 to 80 per cent of patients of both sexes with refractory chronic acne of the cystic and pustular types.[1] "Premarin" Lotion was found particularly suitable because it provides concentration of medication at site of desired action; permits dosage control to eliminate possibility of side effects; and is esthetically acceptable to both male and female patients.

also effective in seborrheic alopecia

Within three to six weeks, control of scaling and itching and reduction of hair loss, particularly about the vertex of the scalp, were noted following application of "Premarin" Lotion, two or three times a day. No systemic effects were noted.[2]

Supplied: No. 875—Bottles of 60 cc. with applicator. Each cc. contains 1 mg. of estrogens in their naturally occurring, water-soluble conjugated form expressed as sodium estrone sulfate.

Detailed information available upon request.

1. Shapiro, I.: Postgrad. Med. *15*:503 (June) 1954; J. M. Soc. New Jersey *52*:6 (Jan.) 1955.

2. Shapiro, I.: J. M. Soc. New Jersey *50*:17 (Jan.) 1953.

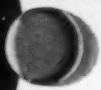
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A really new prenatal supplement

new because—

- *chelated iron*...for exceptional tolerance
- *phosphorus-free calcium*...for freedom from leg cramps
- plus 10 other essential metabolites important in pregnancy



Chelated iron...better tolerance...iron is not suddenly imposed on the duodenum and upper jejunum... hence, no irritation...***better uptake*** ...iron is available over an extended area of the gastrointestinal tract.

Phosphorus-free calcium...avoids the neuromuscular complaints attributed to phosphorus-containing calcium supplements.

Ferrolip OB dosage is small. Just 1 tablet t.i.d. provides:

Ferrolip* (Iron Choline Citrate).....150 mg.	Pyridoxine Hydrochloride...10 mg.
Tricalcium Citrate.....600 mg.	Ascorbic Acid.....200 mg.
Calcium Gluconate.....300 mg.	Folic Acid.....0.5 mg.
Thiamine Mononitrate.....3 mg.	Vitamin B_{12} with Intrinsic Factor Concentrate 1 U.S.P. Unit (Oral)
Riboflavin.....3 mg.	Vitamin A.....5000 Units
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*Protected by U.S. Patent 2,575,611. — Bottles of 60 and 1000 tablets.

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FERROLIP® OB

for your tense peptic ulcer patients



new
ANTRENYL®-PHENOBARBITAL

depresses... ...gastrointestinal motility

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SUPPLIED: Antrenyl-Phenobarbital Tablets (scored), each tablet containing 5 mg. Antrenyl and 15 mg. phenobarbital.

Other forms: Tablets, 5 mg. Syrup, 5 mg. per 4-ml. teaspoonful. Pediatric Drops, 1 mg. per drop.

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KNOX Protein Previews



New Knox Food Exchange Chart
Eliminates Calorie Counting



This year Knox introduced a new dieting plan based on the use of nutritionally tested Food Exchanges.[1] The heart of this new dietary is a "choice-of-foods diet list" which presents diets of 1200, 1600 and 1800 calories.

Each of these diets may be easily modified to meet special needs. However, the important points for your patients are that the use of this chart eliminates calorie counting, and permits the patient a wide range of food choices.

These advantages should make your management of difficult and average cases easier.

1. Developed by the U. S. Public Health Service assisted by committees of The American Diabetes Association, Inc. and The American Dietetic Association.

Chas. B. Knox Gelatine Company, Inc.
Professional Service Dept. ME-6
Johnstown, N. Y.

Please send me ____ copies of the new, color-coded "choice-of-foods diet list" chart.

YOUR NAME AND ADDRESS

Editorials

Sometimes a collection suit doesn't make sense • Branch-office problems • The emergency case • They're making better G.P.s

When Not to Sue

From two sources last month came sharp warnings about the indiscriminate use of the law courts to collect medical bills:

¶ In New York, the state medical society estimated that at least 25 per cent of recent malpractice claims had been generated by "members who sued dissatisfied patients to collect their fees before the statute of limitations had expired for a malpractice suit."

¶ In Erie, Pa., Dr. Elmer Hess reported that hundreds of complaints coming to him from all over the country showed this pattern: "The patient wasn't quite satisfied with the doctor's services—and then the doctor pressed too hard to collect his fee." Dr. Hess, the new president of the A.M.A., added: "Our job as physicians is to satisfy patients . . . When we fail—as we must sometimes—we can [at least] be wary about taking our failures to court."

Since both these warnings appeared exclusively in our pages, we feel under some obligation to link them to basic policy. What should a doctor's attitude be toward taking his patients to court?

We've been gathering opinions on this delicate subject. And here, as a result, are our own:

There are times when collection suits can be distinctly helpful. If the patient has received good services; if he's well able to pay for them; if he's ignored all reasonable collection efforts over a period of many months —under these circumstances a suit makes sense.

As a matter of fact, we've seen such a suit help the whole professional community. How? By putting other delinquent debtors on guard against ignoring their legal obligations.

But now consider the contra-indications: If there's much of a chance that the patient will start a malpractice action by way of reprisal, a collection suit does *not* make sense. And this chance exists more often than some men in practice realize.

It exists in *every* case where the time limit for malpractice actions hasn't run out. Although this varies from state to state, it's generally two

or three years. The time limit for collection suits is generally longer than that. So why ask for trouble by taking any patient to court within two or three years of completing treatment?

The chance of a counter-claim exists even in some cases that have run *beyond* the malpractice deadline. State laws vary here, too. But a few doctors have been shocked to learn that their collection suits automatically renewed the patient's right to file malpractice charges against them. So why take chances by suing before checking this point?

Even when there's *no* chance for legal retaliation, pressing dissatisfied patients too hard can be risky business. Their dissatisfaction tends to spill over into public and professional channels: bridge-table talk, cocktail-party gossip, grievance committee proceedings.

Dissatisfaction, in our opinion, should be recognized as a danger signal. Whenever you detect clear signs of it in a patient, he's probably not the person to sue.

Open a Second Office?

Thousands of medical men these days live in the suburbs and practice in the city. Inevitably, many of them have wondered: "Why not open a branch office where I live? Think of the commuting time I'd save!"

Hundreds have done more than wonder. They've set up that second office—sometimes in their homes, sometimes in a near-by building—and they've manned it several afternoons or evenings a week.

What have they learned from their experience? We've been interviewing two-office physicians, and we've discovered that the idea is far less simple than it sounds. The following opinions may make you properly hesitant about hanging out a second shingle:

New patients don't turn up as quickly in a part-time second office. Referrals from other doctors may be almost nil. Most men who've made a success of branch-office operation started with a nucleus of old patients living in the neighborhood.

Office equipment is apt to be skimpier than downtown. Thus the doctor may be limited to check-ups, injections, prescriptions, etc. This helps explain why general practitioners, pediatricians, and obstetricians usually make out better with a second office than internists do.

Part-time personnel are likely to get less training and less supervision than personnel in the main office. Hence the lower collection ratio that prevails. We've seen some branch-office records so poorly kept that the doctor couldn't tell whether his second office was economically worthwhile or not.

[MORE▶

Serpasil

CIBA

True, a second office *has* proved economically worthwhile in many cases; and that fact alone should interest hundreds more suburban doctors in the idea. But you still have to contend with the difficulties mentioned—and with a lot of legal, insurance, and tax problems besides. So, pending a full report on the subject (we're preparing one), better branch out cautiously if at all.

It's an Emergency!

Some time ago, we printed a cartoon showing a battered, bleeding patient barely able to crawl on all fours into the doctor's office. As he clutches at the receptionist's desk for support, the girl seated there looks up from a magazine she's reading and says with total lack of concern, "Have you an appointment?"

Doctors who chuckled over that cartoon wouldn't chuckle if they thought it applied to their own offices. Yet in some cases it almost does. We've heard several real-life stories lately about battered, bleeding patients who were forced to wait their turn. Why? Because the doctor's aide didn't recognize an emergency when she saw one.

Recognition should properly begin with the first phone call. It takes only two questions: "What seems to be the trouble, Mrs. Johnson?" and then "How long has it been troub-



in varicose vein complications...

striking relief

MY-B-DEN®

(adenosine-5-monophosphate)

Bischoff DIVISION

ulcers begin to heal

pain and burning disappear

pruritus subsides

edema, erythema and tenderness decrease

Full information and bibliography on request

AMES COMPANY, INC. • ELKHART, INDIANA

Just one 'Prydonnal' Spansule q12h

assures sustained, uninterrupted relief

of visceral spasm

and gastric hypersecretion

all day and all night

Upon completion of the clinical trials with 'Prydonnal' *Spansule* sustained release capsules, one of the original investigators volunteered: "I would prescribe 'Prydonnal' in preference to all other products for my patients with spasm."

Why? Because 'Prydonnal' assures effective antisecretory-antispasmodic-sedative action around the clock with just one 'Spansule' capsule q12h. *Even in the patient with a hypermotile gut, the slow passage and continuous absorption of 'Prydonnal' Spansule capsules' hundreds of tiny pellets assure continuous uninterrupted relief of visceral spasm and hypersecretion.*

In contrast to intermittent tablet medication, there are no therapeutic peaks and valleys, no forgotten doses and virtually no side effects with 'Prydonnal'.

Prydonnal* Spansule*

atropine, scopolamine, hyoscyamine plus phenobarbital

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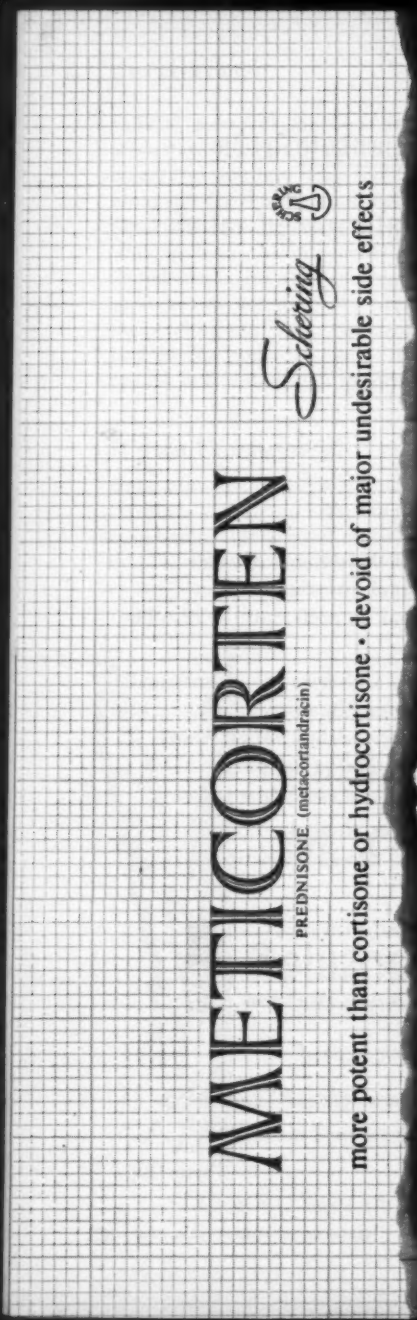
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the originators of sustained release oral medication

*T.M. Reg. U.S. Pat. Off.

Patent Applied For.



ling you?" (If the answer to the second question is "Four days," even the patient may then concede that it's not exactly an emergency.)

Recognition in the waiting room is also important—and not only by the receptionist. Other patients whose appointments are delayed need to know why. Some doctors give post-operative patients red priority cards to display. As a rule, though, personal explanations to the other people waiting are better.

Refresher Requirement

What medicine needs, one physician remarked a few years ago, is "a new type of general practitioner who cannot be relegated to an inferior professional and economic position, as a mere feeder for specialists."

Then the American Academy of General Practice came along. From the start, its main purpose was to "make better general practitioners." It set up a stiff refresher requirement: 150 hours of approved postgraduate study every three years. And during the last two years alone, it has dropped 714 of its 19,000 members for falling short.

For its vision in establishing a policy of self-improvement and for its courage in enforcing that policy, the Academy deserves a round of applause. We hope the time will come when some of our older specialty societies take a tip from it.

—H. SHERIDAN BAKETEL, M.D.



Gastric Hyperacidity: etiology

People being people, environmental factors contributory to gastric hyperacidity are hard to remove, even when their role is clearly defined. But, the physician has a sure, simple—even pleasant—way of relieving the acid distress caused by:

- dietary indiscretion
- nervous tension
- emotional stress
- food intolerances
- excessive smoking
- alcoholic beverages

Gelusil promptly and effectively controls the excessive gastric acidity of "heartburn" and chronic indigestion. And it affords equally rapid relief in peptic ulcer. Sustained action is assured by combining magnesium trisilicate with the specially prepared aluminum hydroxide gel.

Free from constipation: Gelusil's aluminum hydroxide component is specially prepared: the concentration of aluminum ions is accordingly low; hence the formation of astringent—and constipating—aluminum chloride is minimal.

Free from acid rebound: Unlike soluble alkalies, Gelusil does not over-neutralize or alkalinize. It maintains the gastric pH in a mildly acid range—that of maximum physiologic functioning.

Dosage—2 tablets or 2 teaspoonfuls two hours after eating or when symptoms are pronounced. Each tablet or teaspoonful provides: 7½ gr. magnesium trisilicate and 4 gr. aluminum hydroxide gel.

Available—Gelusil Tablets in packages of 50, 100, 1000 and 5000. Gelusil Liquid in bottles of 6 and 12 fluidounces.

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Antacid • Adsorbent

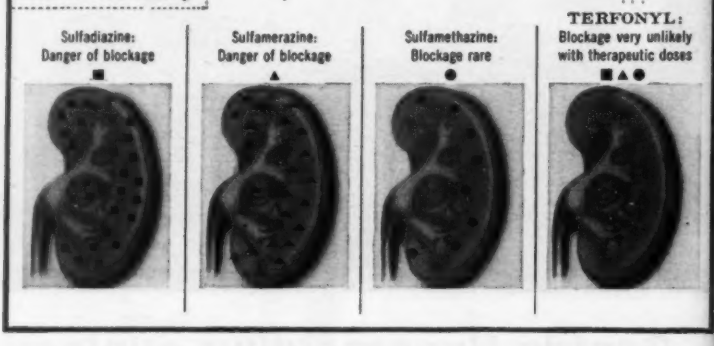
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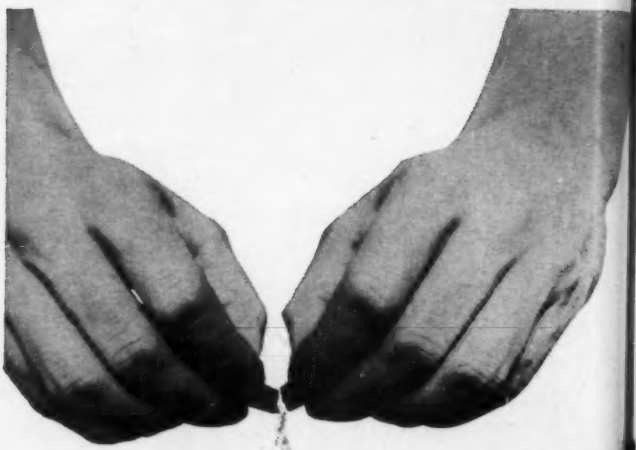
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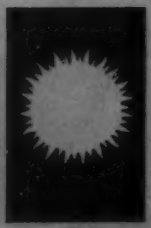
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J. Invest. Dermat. 16:379, 1951.

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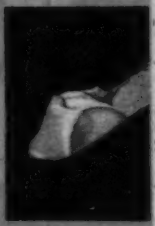




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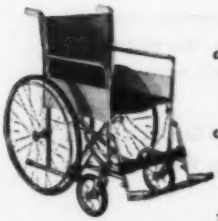
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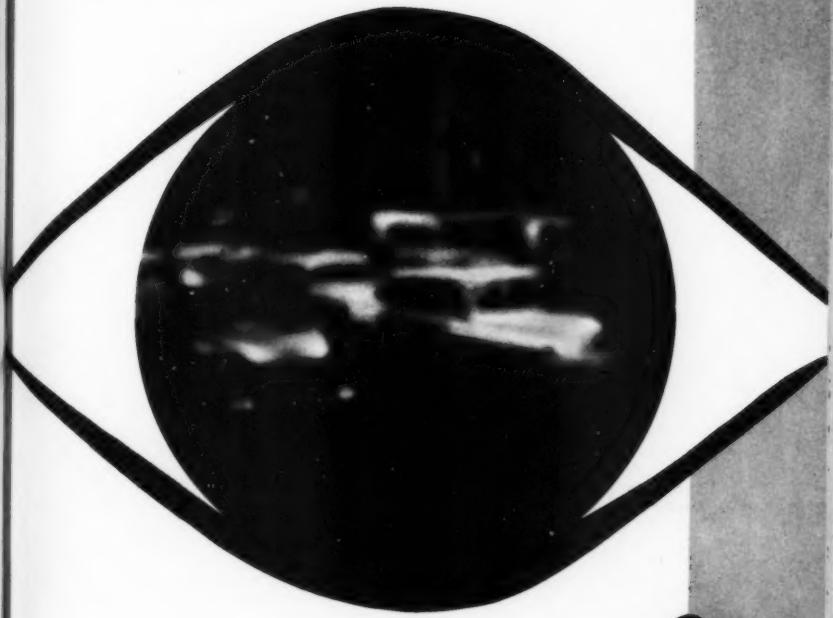
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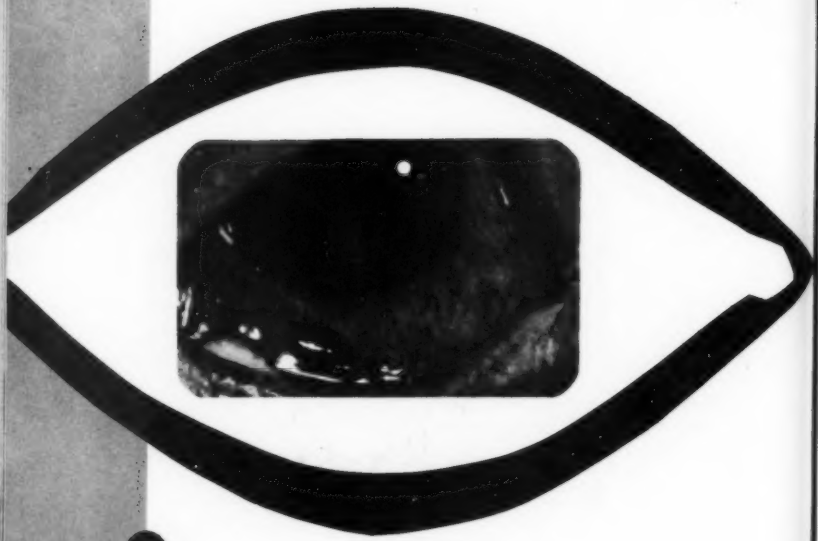
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Are Surgical Fees Too High?

You may disagree with this cool-headed appraisal of the current value of surgery. But you're bound to applaud the writer for his constructive approach to a ticklish subject

By Herbert Berger, M.D.

• Surgery has been traditionally more expensive than other forms of therapy—and, to a degree, justifiably so. We expect, and get, a high degree of dexterity and skill from our surgical specialists.

Yet it seems probable that their fees are *partly* to blame for the profession's unsatisfactory relations with the public—and *largely* to blame for the unfortunate antipathy that exists between the surgeon and his medical colleagues.

I venture into the lion's den with little fear of incurring his wrath. Our surgeons are a fair-minded and altruistic group. Certainly they deny an operation to nobody who needs one. Where the decision to operate, or not to oper-

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THE OPINIONS *expressed in this article are entirely the author's own and do not necessarily reflect the views of organizations he belongs to or of the editors of* MEDICAL ECONOMICS.

ate, is delegated to the individual surgeon, he can almost always be depended on to make up his mind without thought of the economic consequences to himself.

Yet it seems to me that such decisions should not in general be left to the surgeon. He'd be less open to the charge of commercialism if he were answerable only for selecting the kind of operation to be done and for doing it—not for recommending surgery in the first place.

Let the G.P. or internist answer the question: Is an operation necessary? Then the public will accept the procedure with fewer qualms, for the recommendation will have come from a responsible source not involved economically.

This is, of course, the procedure in our great teaching hospitals, in our larger clinics, and in the charity wards of most voluntary hospitals. Not so in private practice. Whether the patient comes direct or is referred by a G.P., the surgeon usually makes the final decision. And I don't think he should.

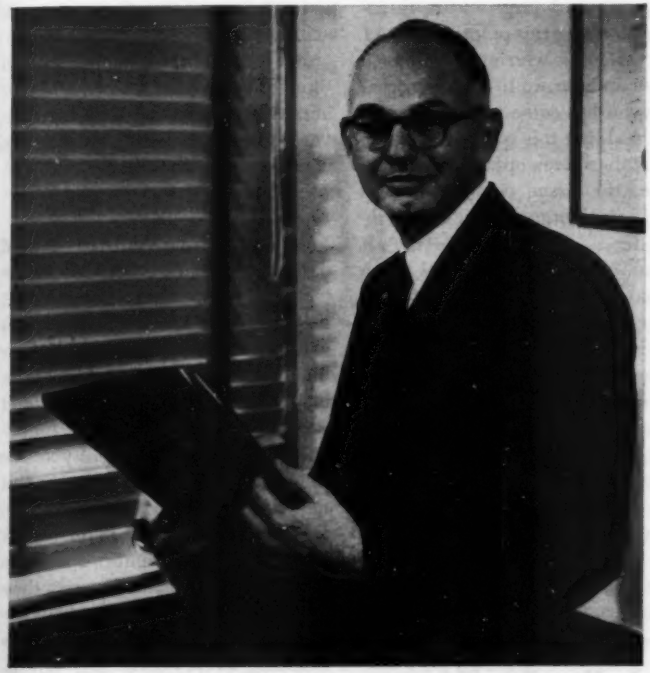
Less Surgery Tomorrow

The surgeon is trained to think in terms of surgical solutions for everything. But, as we all know, surgery is just one form of treatment, and not always the best. The more we progress in medicine, the less necessary surgery becomes. (Remember when operations for empyema and mastoid were common?) So it's often wisest to have someone

DR. BERGER was trained as a surgeon, but he now practices internal medicine in Tottenville, Staten Island—a rural community right in New York City. He wrote this article as the result of a series of talks with union representatives about a local doctor-sponsored prepayment plan.

"The union delegates felt that our coverage could be extended if surgical payments were reduced," he says. "The union members claimed that no one was worth over $100 an hour. They cited as examples the highly trained physicists and engineers in their company. To counter this view, I decided to prepare a defense of surgical fees. But when I sat down to the job, I found I couldn't logically carry it out. Instead, I wrote this article."

Dr. Berger says that he first sent his manuscript—for "opinion and consideration"—to a regent of the American College of Surgeons. "Personally," wrote this surgeon, "I agree . . . that often surgical fees are too high. But I do not



agree with the reasons which you give to sustain your argument . . . I do not believe that any fee is too high if it is based upon the patient's ability to pay."

"To be sure," says Dr. Berger, "the subject is a debatable one. So I'm happy to see MEDICAL ECONOMICS give it a thorough airing."

Dr. Berger is a past president of his county medical society, the president of the medical staff of the Richmond Memorial Hospital, president-elect of the New York City district of the state medical society, and the newly elected vice president of the Medical Society of the State of New York.

who *isn't* a surgeon decide on the advisability of an operation.

A number of surgeons are themselves adopting this point of view. I know of some who even call in a G.P. or an internist to examine a patient who has come to them direct. They feel that this spares them possible embarrassment later—if, for example, the tissue committee finds that normal organs have been removed.

Some surgeons may resent being viewed as highly skilled artisans rather than as diagnosticians. But such is probably their rightful place in the medical hierarchy.

Our failure to understand the proper relationship of surgeon to referring physician, as well as of both doctors to the surgically treated patient, seems to me a prime cause of the growing friction between the G.P. and the surgeon. The G.P.'s services are too often undervalued; the surgeon's are too often overvalued—and thus overpriced.

No More Free Rides?

A quarter of a century ago, the relatively high fees paid for surgery may have been warranted. In those days, patients who could afford a few home or office visits were often unable to pay for surgical treatment and prolonged hospitalization. So our surgeons had to do a great many operations gratis.

As a result, the few patients who *could* afford such services paid substantially larger sums, so as to take care of the many who could not. The surgeon's income then was more or less comparable with that of medical men generally.

But things have changed. With Blue Shield, Blue Cross, and our improved standards of living, private surgery is today within the reach of many families.

Free Operations Rare

As a result, we find free surgical patients rather rarely in our voluntary hospitals. Take, for example, the Richmond Memorial Hospital, a voluntary institution in a relatively underprivileged section of Staten Island: In 1934, only 24 per cent of Richmond's operations were on private patients (and those of you who practiced in those days know that many of these were never paid for). In 1954, on the other hand, 91 per cent of the hospital's operations were private; and collections there now approach 100 per cent.

This reversal has become so pronounced everywhere that our interne and residency training programs have suffered badly from scarcity of clinical material on the charity wards. Recently, I've been serving on a medical education committee that includes several deans of medical schools. They all complain bitterly of the lack of free patients for teaching purposes.

As the insurance companies step ever further into this picture and cover more and more patients for more and more procedures, the un-

paid-for operation becomes increasingly rare. So high surgical fees can no longer be justified on the basis of nonpayment by many patients.

Split Fees No Excuse

Nowadays, fee splitting is almost universally decried. But twenty-five years ago, reputable physicians considered it quite acceptable: It was merely a method of paying the G.P. for his diagnostic study preceding the operation, for any assistance he rendered at the operation, and for his postoperative visits.

Only because some doctors began using fee splits as a method of building up large surgical practices, and because unnecessary surgery sometimes resulted, was fee splitting finally—and rightly—condemned by the profession.

Now then, let's compare an operation performed in the fee-splitting era with one performed today. Take a hysterectomy. Assume that the fee was, and still is, $400.

In the old days, the surgeon got, say, half this fee and the referring physician got the other half. So each received $200.

But now such fee splits are frowned on. It's contended that they victimized the patient. So when today's patient—no longer victimized—gets her hysterectomy and is charged $400, the surgeon keeps the full fee.

The family doctor must then send the patient a separate bill in order to collect for *his* services. This bill may be either more or less than the $200 he would have received under the fee-splitting regime, depending on the type and quantity of work performed.

Now here's the point: The surgical societies have fought tooth and nail against fee splitting; and we might honor them unreservedly if their motives were completely altruistic—if, in other words, their victory had helped reduce the cost of medical care. *But it hasn't.* Instead, it has tended to double the income of the operator and to increase the cost of the illness, since the family doctor must still be paid for his services.

A Case in Point

I don't advocate a return to fee splitting. We're well rid of it because of its obvious faults—e.g., (1) the patient has a right to know where his dollar is going; (2) the secret nature of a fee division cheapens the important service of the referring physician by not acquainting the patient with its value.

Yet the fact remains that the medical man deserves—and will fight to get—compensation more equitably related to that of the surgeon.

Actually, it's quite easy to cite cases where the physician's services may be more important than the surgeon's. Take the decompensated cardiac in labor, for example. Or consider this case:

A woman patient of mine had what appeared to be all the symptoms of Cushing's [MORE ON 269]

What Americans Spend...

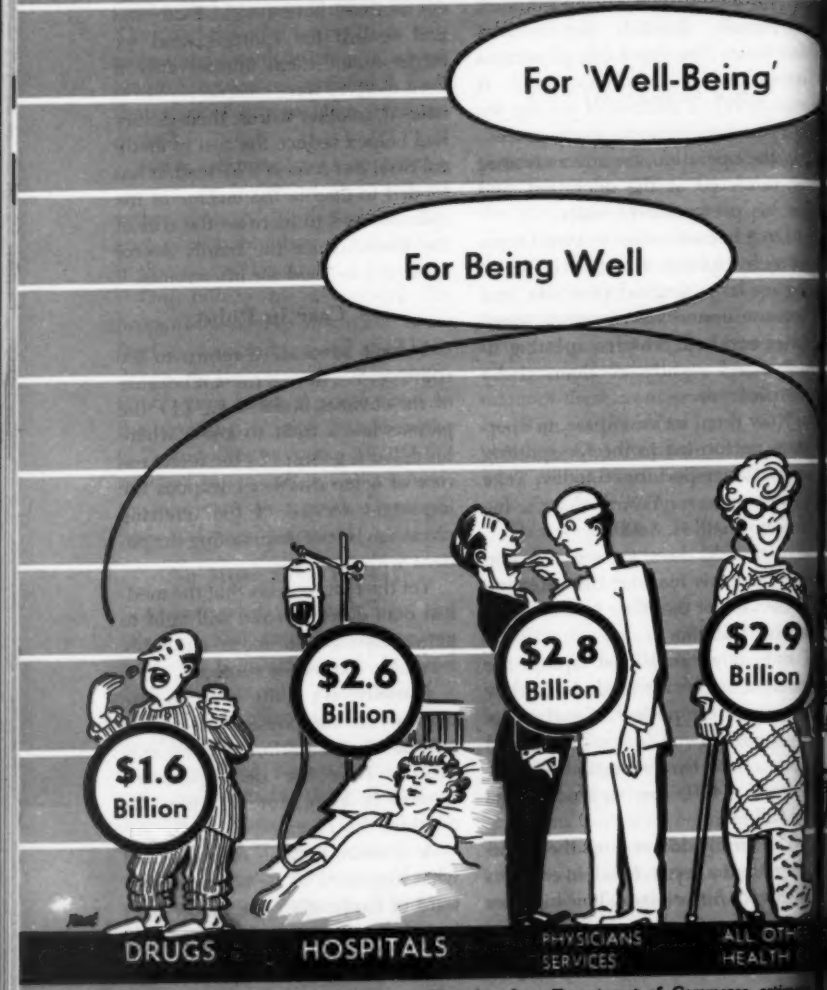


Chart based on Department of Commerce estim



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They Help Young Doctors

Here's how physicians in some of the country's leading medical societies are easing new members into the professional community. They call it indoctrination, and it's getting results

● Recently, a young doctor—just starting practice in a small Midwest city—dropped by for a chat with the secretary of the local medical society.

When it was over and he'd gotten answers to several specific questions, he thanked the secretary and took his leave.

"Oh, there's one more thing," he said, sticking his head



EASY MIXING at indoctrination sessions gives new members a sense of professional belonging and a chance to talk shop with established colleagues. Here, Dr. C. W. McLaughlin Jr. (right), president of Nebraska's Omaha-Douglas County Medical Society, chats with (left to right) Drs. W. C. Boelter, John D. Coe, John Latenser, Richard B. Svehla, and Richard Q. Crotty.

Get Started Right

By
D. A. Drennen

back in the room. "Do I just open my office now and wait for the patients to come in?"

Talk to medical society people and you find that incidents like this happen almost every day. There are armfuls of stories about young practitioners who don't know "where to start," or how to "get in touch" with the professional community, or how to "fit in" with local medical customs and activities.

In one city, medical society leaders had been hearing complaints for months from patients and from established M.D.s about new members who weren't "fitting in." They were overcharging, snatching other doctors' patients, and publicly criticizing colleagues. MORE ▶

Said a local G.P.: "These young fellows seem to think medicine is a tumbling, thumb-in-the-eye sort of business." Said another: "The indications are that they've received little or no instruction in medical ethics or in the obligations of a member to his medical society."

When the situation finally became acute, the medical society did something about it: It established an indoctrination program for all new members.

Within six months, the results were plain—almost dramatic: There was a sharp drop in transgressions by the new doctors, therefore a comparable drop in complaints from older doctors. Many of the junior men said they had a sense of "professional belonging" for the first time since they'd started practice.

Though only a minority of medical societies have yet set up formal indoctrination programs, the idea is gaining acceptance fast. Of seventy-five state and county associations surveyed by MEDICAL ECONOMICS, 36 per cent have—or are planning—indoctrination activities.

What They Do

These programs take place, usually, at the county level. They stress three things:

¶ *Personal contact* between new and established physicians;

¶ *Instruction* in local professional practices, ethics, and ideals;

¶ *Encouragement* of the younger men by their older colleagues.

Medical societies have long had trouble trying to sustain the interest of their younger members in group activities. Such men are apt to attend one or two meetings, then drop out altogether. So indoctrination leaders believe that the more *personal contact* the program can provide, the better. Cocktail parties, dinners, and outings are common means to that end.

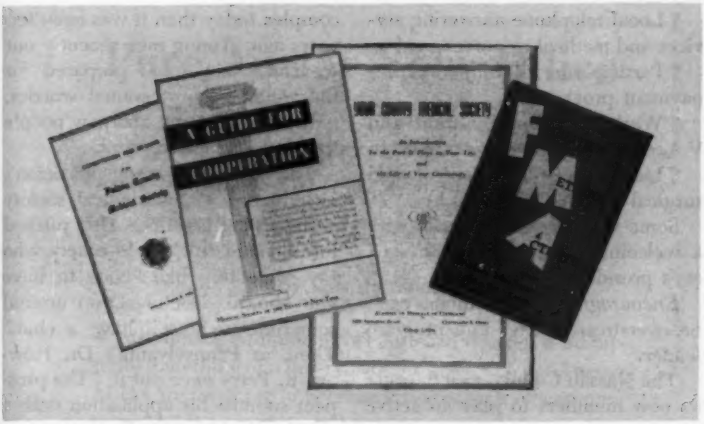
Nebraska's Omaha-Douglas County and Michigan's Wayne County are among those that start off their programs with a luncheon. It's on the house, and attendance is limited to twenty or thirty. Often the new members are asked to act as "hosts." This gets them into the middle of things instead of off in a corner by themselves.

New York's Westchester County society features a cocktail party and dinner—with attendance required. It gives new members lapel cards to ease them over the hurdle of personal introductions.

In Kansas' Sedgwick County, among others, wives are invited.

Some associations combine indoctrination meetings with programs given for seniors at local medical colleges. The state medical society in Nebraska, for instance, sponsors an annual Senior Medical Day for two near-by schools. The program runs through an afternoon of talks and movies, ends with a dinner meeting.

Instruction ranks next in importance to social contacts, and usually



INSTRUCTIONAL READING provided by most medical societies helps new members understand local practices. Information on ethical principles, patient relations, or medical and surgical laws is often prepared by the A.M.A.

encompasses personal as well as professional information. The Nassau County (N.Y.) program, for instance, includes a talk on "The Small Arts of Being a Physician," touching much that is never dignified by mention in medical training.

This talk stresses professional appearance ("always be clean-shaven . . . wear clean linen, never need a haircut"); personal habits ("food should never be worn . . . public cud-chewing is for cows"); professional demeanor ("the day of old Doc Thingummy—who really wasn't any good until after a few drinks—is no more").

In most indoctrination programs, the instruction is compulsory (example: Orleans Parish, La.). But in some, it's elective (example: Montgomery County, Ohio, which offers a choice of six or seven half-hour sessions on licensure and narcotics laws, ethical principles, and insurance).

Nearly all indoctrination programs include some sort of instructional reading—usually in kit form. A lot of it takes the form of literature prepared by the A.M.A.

In Wisconsin, California, Nebraska, and Florida, the state association distributes booklets on

¶ Local medical society aims and activities,

¶ Local telephone-answering services and medical resources,

¶ Participation in voluntary prepayment programs,

¶ Workmen's compensation and V.A. care,

¶ Laws governing medical and surgical practice.

Some wrap up the material with a welcoming letter from the society's president.

Encouraging new members can't be overstressed, says one program leader.

The Nassau County society urges its new members to play an active part in society and community functions. "Just because you're new," it says, "don't think we aren't concerned with you and your progress."

But why have indoctrination at all, some may say. Why do young practitioners need a program to tell them about starting practice? Or getting on with colleagues? Or understanding their society?

Because medicine is a lot more complex today than it was even ten years ago. Young men recently out of school just aren't prepared for the welter of professional worries, unfamiliar customs, and new people they must adapt to.

Too often, the young physician's introduction to his medical society is something like this: He's pushed into a room full of old-timers who say something like "Nice to have you aboard, Doctor. Drop around sometime and we'll have a chat." Then, as Pennsylvania's Dr. Howard K. Petry once put it, "The prospect submits his application with a check, the board of censors approves, a perfunctory election takes place, and he is asked to rise and be greeted by a standard clap of hands."

Proper indoctrination methods offer a sharp contrast: They make the new doctor really feel wanted. They give him a hand with his problems. And they help keep him on the path of righteousness. END

Man and God

● I was having scant success getting a medical history of a fourteen-year-old patient from his taciturn father.

"What doctor has been treating your son?" I asked.

"No doctor," he said. "My son's always healthy."

"But you told me he had his tonsils out last fall. What doctor removed them?"

"No doctor. The Blue Cross." —ARNO GRADNAUER, M.D.

Pure Air for Your Office

You and your patients can breathe more easily after you put one of these new cleaners or filters to work removing air-borne dust and pollen

By Lois Hoffman

● Air-filtering equipment, like air conditioning, is admittedly something of a luxury. But it's one that a good many M.D.s are investing in because it makes their offices more comfortable to work in and to visit.

A high proportion of air-borne dust, soot, and pollen can be eliminated by a good filter, which thus makes it easier to keep the office clean. Some cleaners freshen the atmosphere, too, by removing tobacco smoke and by mixing outside air with the recirculated air.

Commonly used air cleaners and filters are of two general types: mechanical and electrostatic.

Mechanical filters trap large air-borne particles (soot, lint, mature pollen, etc.) in a maze of metal screen cloth, spun glass, or similar material. The most effective ones are coated with a viscous oil to hold the dirt.

Either permanent or throw-away mechanical filters can be installed in any central air-circulating system. In fact, you may already have one of them in your air-conditioning or ventilating system. (Some of these built-in filters are pretty shoddy, though. So you'll do well to consider replacing yours with a different brand or type if it's not working efficiently.)

If your hot-air heating system is relatively new, it probably has a built-in frame to hold the required number of

standard filters. Or such a frame can be installed by your local sheet-metal shop for a few dollars. Then you just slip the filters into place, where they clean the air automatically as it circulates in the system.

Price Is Low

Sufficient throw-away filters for a six-room building will cost about $2 to $4. They must be replaced two to six times a year, depending, naturally, on how dirty the air is.

Permanent mechanical filters cost more initially than throw-aways (perhaps $8 or $10 for a six-room building). But since they may last for years they're cheaper in the long run.

One drawback: They must be removed and washed regularly—preferably in a solution of hot water and a grease solvent. After they've drained dry for an hour or so, they get another coating of oil, which is most easily applied with a small spray gun. Some doctors like to buy a few spare filters, so there's always a clean one ready to replace the one that's being washed.

Electrostatic cleaners have been used in auditoriums and other large buildings for a number of years. But now they've been adapted for use in small office buildings and even single rooms.

Does Away With Smoke

If you want to remove even the tiniest particles of smoke, dirt, and pollen (some bacteria, too, incidentally) a good electrostatic cleaner will do the job. Such cleaners are said to be a particular boon to patients affected by air-borne allergens. [MORE TEXT ON 113]





MOVABLE ELECTROSTATIC CLEANER (in 30" x 15" x 15" cabinet) will usually clear the air in a single room quicker than a central air-filtering system would. It's used in many medical office buildings where the cost of installing a central electrostatic unit would be prohibitive. The metal collector plates can be removed and sprayed with a hose or dipped in a tub every month or two.

◀ **CENTRAL ELECTROSTATIC CLEANER** like this one adds fresh air to recirculated air and strains out impurities. It then routes the air into the heating or air-conditioning unit. When the filter plates are dirty, you flick a switch that starts up a built-in washing mechanism.

Commonly Used Air Filters and Cleaners

Type	Installation	Removes	Top Efficiency (dust-spot test)	Maintenance Of Plates	Cost
Throw-away, mechanical	In air ducts	Soot, dirt, large pollen	20 per cent	Discard when dirty	Low
Permanent, mechanical	In air ducts	Soot, dirt, large pollen	20 per cent	Wash, recoat with oil	Low
Movable, electrostatic	Plug in wall socket	Large particles, bacteria, pollen fragments, smoke, fumes	90 per cent or better	Wash	Moderate
Central, electrostatic	In air ducts	Large particles, bacteria, pollen fragments, smoke, fumes	90 per cent or better	Discard; or wash; or employ built-in washer	High
Carbon	In air ducts; or plug in	Odors, some large particles	———	Send to manufacturer for reactivation	Moderate

Here's how an electrostatic cleaner works:

Dirt particles (drawn into the filter by a fan) are given a positive electrical charge, which makes them cling to negatively charged collector plates. These plates, like those in a mechanical filter, may have a viscous coating to help retain the dust, and may be of either the permanent or throw-away type. Some units using permanent filters have a built-in washing mechanism.

Operating Cost

Even a good-sized electrostatic cleaner uses less current than a 60-watt light bulb, so the operating cost is low.

If you have standard hot-air heating or air-conditioning equipment, it probably doesn't include a built-in electrostatic cleaner now. But one can usually be installed in existing ductwork without too much trouble and expense.

Most of the smaller units can be mounted overhead in the furnace room. A large model, though—say, one for a twelve-room medical office—needs a square yard or so of floor space.

A central electrostatic cleaner for a six-room office costs in the neighborhood of $350, plus installation. In a new building, the charge for installation may be as little as $25, since the connections can be properly planned and the electricians and other workmen will have to be there anyway.

But in an old building you'd better figure on paying an installation charge of from 30 to 100 per cent of the cost of the equipment itself. Reason: Electrical circuits, ductwork, and plumbing will usually have to be put in, added to, or rearranged.

Plug-In Unit

What if your building has hot-water or steam heat and no central air conditioning? You can then purify the air in any room with a movable electrostatic unit—the kind that plugs right into a regular wall socket. Such a unit costs about $230 and, of course, entails no installation charge.

None of the filters or cleaners described will do an entirely adequate job of destroying chemical and organic odors. But activated carbon will. For about $150, you can buy a carbon filter with a special frame to fit in the ductwork. When the filter is saturated—in six months or a year—the manufacturer will reactivate it for $25 or so.

Movable Carbon Filter

Or, if you want to remove odors in one room only, you can buy a movable unit (of the type sometimes used in hospital rooms) for about $400. This unit has both activated-carbon and throw-away mechanical filters.

Air filters are sold by local dealers and by medical supply houses. For dealers' names, look in your classi-

fied telephone directory under "Filters—Air." Or you can ask a heating contractor or engineering firm for advice.

In comparing brands, find out how many cubic feet of air per minute each unit will handle. Find out, too, the proportion of typical airborne impurities (not a coarse, synthetic, test dust) each type will remove. Here, it's important to note the standard of measurement used: Is it a *weight* test or a *numbers* (National Bureau of Standards "dust-spot") test? A mechanical filter, which removes mostly large, heavy particles, may be 99 per cent efficient by weight, but probably no better than 20 per cent by number.

On the other hand, a good electrostatic cleaner will show at least 90 per cent efficiency in a numbers test, since it traps large and small impurities alike.

The type of filter or cleaner you choose will depend, of course, on what you want to accomplish—and on how much money you want to spend:

Least expensive is a good mechanical filter. This will do an effective job of keeping your office air free of large impurities.

Next in the price scale is a movable electrostatic unit. Such a cleaner, used in one room, will virtually eliminate both large and small particles (including smoke and pollen fragments that would slip through a mechanical filter).

Finally, there's the central electrostatic cleaner. This fits the bill when price is secondary to building-wide comfort. END

Effervescent Therapy

● One day when I was out of town, a man phoned my office to say that his daughter was covered with mosquito bites. What should he do?

My nurse suggested he try some soda on the bites until I could see the child in person.

Next day a glum father and a still-itching daughter appeared at my office.

"She ain't no better at all," he told me. "I used soda like the nurse said; but it just didn't do no good."

Suddenly he brightened with an inspiration: "Maybe, instead of orange soda, I could try Coca-Cola—huh?"

—MARTIN ASCH, M.D.

Buy That Second Car —Or Lease It?

This summary tells what car leasing offers, how much it costs, and where it's available

By Thomas Owens

● Are there two cars in your garage? If so, here's a question worth considering:

Would you be better off owning only the family auto and leasing your professional car? Some M.D.s are finding (as business firms discovered long ago) that leasing can be a better deal than buying.

Most of the doctors I've talked with who go in for leasing say they're attracted to it not because it's cheaper than buying (generally speaking, costs are about equal) but because of other advantages it offers. For instance:

¶ When income-tax paying time comes around, you have a ready-made financial record: Your receipted monthly bills justify the expense deduction you claim for your professional car. This convenience alone, claims one G.P., makes leasing worthwhile for him. "Before I began to lease," he says, "I could never prove how much it had cost me to run my car. So I'd put down a lower figure than I should have, just to prevent trouble with the tax men."

¶ You don't have any capital tied up in the car. Instead, you keep your money earning interest and readily available for any emergency.

¶ You're certain you'll never be without a car. If the car you've leased isn't available for some reason, you'll get a

replacement immediately. Normally, a new car won't need major repairs. But other things can happen. For example:

One day recently a New York City doctor rushed out from his mid-town office to begin a heavy round of calls. When he reached the sidewalk, he pulled up fast. The new 1955 Pontiac that he'd parked at the curb an hour before was gone—stolen in broad daylight.

His reaction: "I didn't cuss, didn't rush for the police, didn't commandeer my wife's car. Nor did I spend money on cab fare. I simply telephoned the firm that leased me the car. They had a replacement over in ten minutes."

Those seem to be the major advantages that M.D.s find in leasing. And for some doctors it may also be slightly cheaper than buying a car. Would it be so for you? It's impossible to give an answer that would be universally true, because the prices of new cars and the trade-in values of old ones are so flexible today.

So you'll have to do a bit of arithmetic before deciding that leasing's cheaper for you—particularly if you now own a professional car. (One point to keep in mind: Leasing seems to cost more than buying if you're a low-mileage driver who can keep a car two or three years without major repair bills.)

But if you're a one-car physician who's thinking of getting a professional car—and a new one every year—it's a bit simpler to compare costs of buying and leasing. Here, for example, is how a doctor in Hillside, N.J. figured it out recently:

Rental on Leased Cars

Make of Car	Monthly Rental
Ford, Chevrolet, Plymouth	$ 85 to $110
Pontiac	100 to 120
Cadillac	140 to 150

To lease a four-door Chevrolet sedan (210 series) for one year would cost him $1,164 (at $97 a month). For that he'd get radio, heater, signal lights, and seat covers. The monthly fee would include everything but gas. That meant: insurance protection, registration, inspections, lubrication, new tires if necessary, and a substitute car in case of damage to the one he had.

Two limitations were written into the contract: an annual mileage allowance of 24,000 miles, and a clause in the $50-deductible collision insurance policy specifying that the doctor would pay for damages under that amount.

This G.P. figured that if he bought the same car (at the discount price of $2,160), one year's costs would

total about $1,200. This figure included: $800 for the first year's depreciation (not too high in today's cut-rate market, he was told); $190 for the same-insurance coverage as on the leased car; $22 for registration; and $100 for maintenance. Also, since by buying a car he'd be tying up an average of about $1,500 more than by leasing, he figured interest lost on that amount at 6 per cent and added $90 to the cost of buying vs. renting.

After noting that buying or leasing would cost him about the same, this New Jersey physician decided to lease. Here's how he looked at it:

"If I buy a new car, I'll get a ninety-day guarantee. But if I lease a car, I'll get the equal of a twelve-month guarantee."

Though leasing seems to offer many advantages to the busy doctor, not too many M.D.s actually do lease cars as yet. How come?

Non-leasing doctors whom I talked to usually gave one of these two reasons: they'd never heard of the idea before, or they'd heard of it but never stopped to figure out whether it was worthwhile. (Actually, it isn't surprising that so little is known about the subject; for long-term leasing to individuals really began after World War II.)

Though doctors in general may need more information about car leasing, those in one area, at least, have investigated it quite thoroughly: Last year the medical economics committee of the Bronx County (N.Y.) Medical Society made a study of car leasing. They wanted to find out if it offered substantial advantages for the average doctor. The committee reported:

Many doctors (especially the high-mileage G.P.) would probably be better off financially with a leased car. And there were definitely non-monetary advantages for any M.D. The committee felt, though, that members should check their own individual situations before deciding.

Actually, a good many Bronx doctors did sign contracts with the New York firm that the committee selected as offering the best deal. To date, reports the society's executive secretary, there have been no complaints —only enthusiastic approval from the doctor-lessees.

These New York physicians are the only ones I've heard of who've

Insurance on Leased Cars

Type of Policy	Usual Limits
Liability	$250,000/ $500,000
Property damage	$50,000
Fire, theft	Full value
Collision	$50-deductible

gone in for leasing in an organized way. But the service isn't limited to big cities. Car-leasing firms can be found in any fair-sized city.

The two nation-wide companies that specialize in short-term rentals (Hertz and Avis) also lease cars for longer periods (twelve to eighteen months). But central headquarters of each of these systems reports that since local branches operate independently under their own franchises, you may find some managers who don't as yet offer cars on an annual-lease basis.

These national corporations aren't the only ones in the leasing business. A number of dealers whose major business is selling cars also offer them on lease. But the smaller firms usually don't advertise. So you may have to make a few phone calls to locate a dealer who leases.

Incidentally, you probably won't be greeted by a high-pressure salesman if you do drop around to such a firm. Dealers have found that when they talk fast doctors become suspicious and back off. Companies that lease cars also say there are two common problems with doctors:

¶ Most leasing companies are accustomed to supplying fleets of uniformly outfitted (and usually low-priced) cars to business firms. But some doctors want more expensive cars, unusual color combinations, or special accessories; and a small leasing firm may hesitate to set up a special program for a few cases.

¶ A doctor may just naturally shy away from signing a contract. Even though the company urges him to have a lawyer read through it first, the doctor sometimes feels that it's too much trouble. He'd like to see a much simpler document, less encumbered with legal jargon.

Such problems, though, aren't discouraging the leasing companies. They're sure that the big potential market among physicians will come alive when doctors become more used to the leasing concept. END

True Confession

● George Johnson and Ruth Johnson came to my office for a premarital examination.

Since both had the same last name, I initiated some polite conversation by asking, "Relations?"

Ruth reddened, then, with lowered eyes, replied:

"Just once. George couldn't wait."

—STANLEY E. ANDERSON, M.D.

Latest Comic-Book Hero: The American Doctor

A gaudy new bimonthly sings the praises of the physician to the great comic-book-reading public

By Paul W. Fairfax

● First it was Li'l Abner. Then Wild Bill Hickock. Now it's *you*—Dr. Whatever-your-name-is—the current idol of the comic-book set!

Don't laugh. This is stern stuff. There's a new comic on the newsstands, "dedicated to Mankind's tireless and unceasing battle against disease, and to the man who fights that never-ending battle day after day . . . your Family Doctor . . . your M.D."

"At times,"the dedication says, "our stories will be poignant . . . at times they will be sad . . . at times they will be grim. But at all times they will be *true to life!* And now . . . we, the editors . . . offer the vow taken by all M.D.s . . . 'The Hippocratic Oath.' "

With those historic words on its opening page, the comic called M.D. introduces itself. The solemnities over, it then gets down to business.

Except that its derring-do is performed by doctors, M.D. is much like other adventure comics published for the young (chronologically or intellectually). Thirty-six pages of lusty tales, all vividly illustrated, comprise each issue. Fables Publishing Company of New York, the owners of the property, call it "a New Direction in magazines" that, for the first time, brings medical drama to our comic-reading millions.

[MORE ▶



FRONT COVER of the first issue of M.D. is calculated to capture readers for five adventure tales inside that combine "education and entertainment." Plots all center around medical procedures. Each hero is a doctor.

"Quite frankly, M.D. was inspired by the television program Medic," says the comic book's editor, Albert B. Feldstein. "We wanted a magazine that would be equally frank, dramatic, and honest."

History in the Raw

The first story in the first issue of M.D. is billed as a history of medicine. Under a drawing of something akin to an ape man is this caption: "A face agonized . . . a doomed face . . . a face with the ravages of hideous pain etched into every shrieking fold and feature . . . This is the face of mankind helpless before the onslaughts of disease . . .helpless to save itself . . . waiting, since the dawn of civilization, for *the doctor* to appear on earth."

Pending the medical man's arrival, a series of grim scenes is unfolded: brutal body beatings to drive out demons; the administration of stomach-turning medieval medications; trephines, without anesthesia, on screaming victims; etc. Editor Feldstein admits now that this sequence was perhaps "slightly overdrawn"; the other stories are clinically a bit less graphic.

A picture feature, called Janie Some Day, tells of a persistent osteomyelitis, a leg amputation, and the rehabilitation of a small girl. Another, about an emergency appendectomy, shows the reader that the doctor does so have feelings.

Still another story describes the familiar household process of tucking the doctor's bill under all the rest. This folly nearly turns to disaster when an emergency tracheotomy is indicated and the debtor can't find another M.D. The first doctor, when finally called, comes at once, of course. But the reader is left with a firm moral and economic lesson to ponder.

One of a String

The unseen teachers of such lessons—the publishers of M.D.—are neophytes at newsstand education but old masters at entertainment. They turn out a whole string of comic books, from the adventurous to the zany, including Valor, Aces High, Piracy, Incredible Science Fiction, Mad (slapstick fantasy), and Panic (more of the same). They've also started a sister publication to M.D., called Psychoanalysis, that peeks through the keyhole at the psychiatrist.

Readers Unknown

M.D. is addressed to readers of fourteen and older, says its publisher, William M. Gaines. But there's no way of checking who actually gets it. (Adults, rather than children, buy most of the 700 million comic books sold annually.)

Some 350,000 copies of M.D.'s first issue—at 10 cents a copy—were distributed in February to newsstands from coast to coast. The second issue appeared in May. Bimonthly publication is planned if the magazine is popular enough.

Like many comic books, M.D. submits to the censorship of the Comics Magazine Association of America. This is the self-policing organization set up by the comics publishers to weed out material that might be considered offensive. M.D. bears the association's stamp of approval. (It was given to the May issue only after a good deal of wrangling and the deletion of several graphic operating room scenes that the association thought would be unsuitable for children's eyes.)

Fact-Checking

The association doesn't concern itself, of course, with medical authenticity. This is left to the comic's freelance writers and artists who are supposed to guarantee their facts. They do this, Mr. Feldstein explains, by consulting their own physicians. Then the editor, who says frankly that he has no medical background, re-checks with his own doctor. There are no staff medical advisors or ties with medical societies.

A careful medical reader *will* put his finger on a few technical errors. But the stories *are* plausible; and no



'PAY YOUR PHYSICIAN' is the theme of this melodramatic sequence. Story's wind-up is shown in the panels on the opposite page.

substantial misstatement of medical fact has been noted so far.

What *might* be objected to by the profession, judging from M.D.'s first issue, is the emphasis on sadism. Most physicians would be offended, too, by the medium's screaming colors and by its general flashiness.

Yet M.D. is obviously not meant for sophisticated readers. And it does show the doctor as a reputable figure—which is more than can be said of some of the serious (and popular) literature on the subject. It delivers a message of health education as well as a vote of confidence in the profession.

Gaudy as it is, M.D. will perhaps reach more readers and affect them more than do the ponderous devices often dreamed up by public relations committees. It may even help offset those "doctors-should-be-in-jail" articles that appear so often in magazines and newspapers.

Just don't be surprised, though, by your wife's parting words next time you leave the house:

"So long, Hero! See you in the comics!"

END





TV 'For-Doctors-Only' Hits the Big Time

Post-graduate study is getting a vigorous boost from network clinics, and hospitals are starting to lean heavily on TV for student training

By Lawrence C. Goldsmith

● "Swing over that scoop, Bud. Give us an inky and two babies, so's we can pan down on the table."

Strange talk in a medical auditorium? Strange, yes—but growing more and more common as television, a gimmick in medicine just a few years back, hits its stride as a major medium for post-graduate (and medical school) training.

Few doctors have mastered the technical jargon—such as these terms for lighting equipment and camera angles. Yet thousands have watched the resulting TV programs staged for their benefit. Scarcely a month goes by that M.D.s somewhere aren't alerted to a medical TV panel, symposium, or demonstration—often sponsored jointly by a medical society and a pharmaceutical house. [MORE ▶

CLOSED-CIRCUIT TELECASTS, shown to medical men gathered simultaneously in cities from coast to coast, have had audiences as large as 54,000. This one is a demonstration of a Caesarean section. Some medical bodies give study credit to physicians attending such post-graduate television clinics.

The shows have ranged from a display of surgical procedures in a local hospital operating room, seen by a handful of viewers in a near-by lounge, to network programs that come close to what show business calls a TV "spectacular."

Most dramatic of all was the moment, a few hours after release of the poliomyelitis vaccine report on April 12, when a closed-circuit telecast enabled doctors in seventy-five cities to get firsthand details from Dr. Jonas E. Salk, Dr. Thomas Francis Jr., and other leading participants in the project. By attracting an audience of 54,000 in the U.S. and Canada, this telecast, sponsored by Eli Lilly and Company, set a new record in the quick dissemination of professional information.

Other attendance figures are impressive, too. At one super-forum recently piped by Wyeth Laboratories to auditoriums in twenty-six cities, as many as one out of every three local physicians showed up. And at another, produced by Smith, Kline & French Laboratories, more than 23,000 M.D.s saw a program costing well over $75,000, with no outlay for the opening speaker, Dwight D. Eisenhower.

For this princely sum, the sponsors who paid (S.K.F.) and the sponsors who gathered the audience (the A.M.A.) were able to offer regal fare. Thirteen leading cardiologists—serving, like the President, without compensation—compared their latest notes on diagnosis and therapy.

Five of these specialists made up a panel that met on the stage of a New York City theatre. From time to time they were joined by colleagues hooked up "live" or on film from other cities. To nail down points, they showed charts and animated diagrams. They even tuned in on a "live" doctor-patient interview. All this could be seen by the doctor-only audiences on theatre-sized screens in darkened hotel ballrooms and theatres.

Short but Sweet

What they got, of course, was a capsule briefing. And, as one man said, he could have read it all in manuscript form a few days later in the comfort of his study. But his wasn't a typical remark. Much more so were these:

"I learned more tonight in an hour and a half than I could have by devoting all my spare time for a week to reading."

"I'm too tired at the end of the day to read, but I *can* look."

"This is the most outstanding development to date in post-graduate education and review."

Clearly, medical television has graduated from its primary-school days. Those were short, but zippy, with most of the emphasis on "firsts." From the moment the TV camera invaded the operating room—at Johns Hopkins in February, 1947—

producers have been vying for the biggest collection: the "*first* program of medical significance," the "*first* color demonstration," the "*first* use of three cameras," the "*first* international medical telecast," etc.

A Few Highlights

But, aside from this race for kudos that's of little interest to medicine, TV *has* piled up an impressive record of service. Here are just a few examples:

¶ Smith, Kline & French, one of the genuine "firsts" in the field, has been barnstorming medical meetings for six years, besides presenting its big network "Videclinic" on cardiology and another on psychiatry. S.K.F.'s usual medical-meeting TV program is a short clinical presentation in color on a large screen. It may be anything from a demonstration of electroshock therapy to a discussion of the medical uses of radioisotopes.

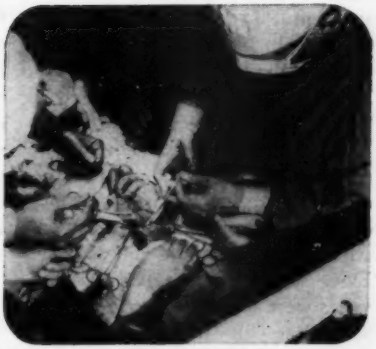
The company's ten-man mobile television station—the only one in the country—handles the technical arrangements. So far, S.K.F.'s "box-office" count is nearly a third of a million doctor- [MORE TEXT ON 130]

PANEL DISCUSSIONS give up-to-the-minute briefings on research. Success of the conference idea has inspired one commercial firm to plan weekly telecasts to M.D.s later this year.





TV IN SURGERY is now standard equipment as a teaching aid in several hospitals. The camera, hung amid the overhead lights, doesn't interfere with the surgical team. A tiny microphone tucked inside the chief surgeon's mask carries his commentary to viewers in near-by auditoriums.



ACTUAL PICTURE as it appears on the TV screen. Watchers from a distance get the same view of the surgical field as do the surgeon and his first assistant.

WORKS BOTH WAYS. Students like these, listening to a surgeon's explanation, can telephone questions that reach him via a loud-speaker. This photo—of a color telecast of an ophthalmologic procedure—also shows the extent to which a small area, such as the eye, can be magnified by the TV camera. [MORE ►



visits. Some 60,000 more are anticipated in 1955 at programs given before fifteen medical conventions.

¶ Wyeth Laboratories has conducted two important coast-to-coast TV symposiums—one, with the American College of Physicians, on hypertension and another, with the American Academy of General Practice, on streptococcal infection. Medical communities in sixty-six cities saw the latter. Five of the cities were in Canada, marking the first time the two nations were linked in a medical post-graduate closed-circuit program.

Report on Cancer

¶ The American Cancer Society, a year ago, presented a round of thirty telecasts on malignant disease. The series made history on two counts: It covered its subject solidly (not sketchily, as some other programs have been forced to do); and it buried the myth that TV was attracting medical audiences only as a novelty. In several of the seven cities where the programs were watched, audiences grew from week to week. The man who came as a sight-seer returned, more often than not, as a serious viewer.

In only one noteworthy instance, so far, have medical men been able to view a series of clinical telecasts in the comfort of their own homes. That was late in 1953, when the University of Utah College of Medicine routed local medical men out of bed in the early hours of the morning. They didn't object overly much to *that*, and not at all to the substance of the eight-part post-graduate series, which was excellent. But a few of them *were* uneasy because the telecast was on an open circuit, which meant that night watchmen, insomniacs, and early-risers could tune in on their own sets. The wall of professional privacy had open knotholes in it.

How It's Done

Ever since then, medical TV has generally stuck close to the closed circuit. (That's as of now. As I'll mention later, there may be a return to the open airwaves—with a precautionary twist.)

Ordinary home TV sets pick up *open*-circuit programs from the air. These programs are telecast from a high tower or mountain top, and can be received by any set within a wide radius. So the open circuit is pretty much like a telephone party line.

The *closed*-circuit program, by contrast, is like a private telephone conversation, usually long-distance. The program is sent over a telephone cable that must, at the receiving point, be attached to a particular set. No unauthorized viewer can look in.

Privacy can also be assured by *microwave* transmission. This sends the image through the air but aims it at a particular target. It's usually in conjunction with cable transmission.

Any of the 254 U.S. cities linked

by telephone-TV cables can receive —or transmit—closed-circuit programs. So they're not confined to the biggest centers. Actually, some of the small medical communities have taken greater advantage of viewing opportunities than have large ones in metropolitan areas. One reason for this, of course, is that conventional opportunities for refresher training are more limited in small cities.

Only one section of the country—the northern Rocky Mountain region —is still blacked out. But it's considered only a matter of time before the entire nation will be blanketed.

Is it easy to arrange a TV hookup? No. To liven up your medical society's next meeting, for instance, with a one-hour closed-circuit telecast from a hospital 100 miles away would take extensive planning. You'd be involved with television stations, telephone companies, and technical crews. And it would probably cost you close to $1,000 for cable facilities alone.

For Local Telecasting

On the other hand, you can establish your own intramural television station for less than $5,000—if you keep your receivers within 600 feet of the point of origin. Maintenance costs of such a station may run as low as $4,000 a year (mostly for personnel).

More than a dozen medical schools and teaching hospitals across the country have installed intramural facilities. And, as training aids, they report, they're sure-fire.

Some teaching centers telecast daily, some only once a week. But *all* of them now seem to regard their equipment as indispensable. (At least one surgical supplier is now advertising instruments with a dull finish that won't glare into the TV camera!)

It's in surgery, of course, that the TV camera is finding its widest use. At the Army's Walter Reed Medical Center in Washington, D.C., for instance, color TV sets are used in the training of medical officers, students, and nurses. The galaxy of equipment there is valued at $150,000 and requires a fifteen-man technical crew to operate it.

Front Seats Aplenty

A more typical example of local telecasting is at St. Vincent's General Hospital in New York City. There, three of the operating rooms are equipped for color that can be seen on nine TV receiving sets placed in the medical conference room and in the nurses' auditorium. Sometimes, the hospital sets up a large screen to accommodate still bigger audiences (as it did when it put on a surgical clinic day for the Brooklyn-Long Island chapter of the American College of Surgeons). Normally, though, the nine-inch screens of the television sets are adequate.

Only one technician is needed by St. Vincent's to [MORE ON 257]



No Parking Problem Here

Ferd Callison's entire list of patients—one after another—could spin up the ramp of this $3,875,000 garage he's built in San Francisco

By Eric Haskell

● Self-parking, indoors, is what Ferd W. Callison, a San Francisco surgeon, now offers his patients (and others in that city)who drive downtown.

Dr. Callison's office is three short blocks from the garage. His patients are delighted at the time they save by being able to park so close to their destination.

In less than two minutes, a driver can sail up a one-way spiral ramp to the garage floor he's been assigned to. He parks in an individual diagonal stall, locks his car, and takes an elevator to the street. Later, when he picks up his car, another ramp spirals him down to the street.

Dr. Callison gives each patient a stamp, good for an hour's free parking. Other M.D.s and dentists—plus more than 150 near-by business concerns—are also using this goodwill-builder. For each one-hour stamp, the doctor or company that buys it pays 15 cents (the regular charge for a daytime hour is 25 cents).

Dr. Callison dreamed up the strikingly modern, self-parking garage himself. He holds a controlling interest in (and is president of) the corporation that owns it. He

AT OPENING CEREMONY, Dr. Callison gives the first free-parking stamp to Mrs. George Christopher, wife of the president of San Francisco's Board of Supervisors.



originally expected an average daily turnover of 3,600 cars; but it now appears that the number will far exceed that. There's space for 1,200 cars at one time, and the garage is now often filled. It was opened in March of this year.

Helps His Practice?

It's too early to tell, Dr. Callison says, if the availability of parking will substantially increase his—or any neighboring doctor's—practice. But it stands to reason, he feels, that "it should remove the objection many patients have to driving into the crowded downtown area." Two large medical buildings are in the vicinity of his garage.

Although this is Ferd Callison's first garage venture, he's long made a hobby of seeking ways to relieve traffic congestion. He spent four years studying the type of solution afforded by self-parking facilities.

The search for a good design led him, strangely, to the archives of Benito Mussolini. The late Italian dictator conceived the notion of a double spiral ramp, but never had one executed. Dr. Callison adopted and improved the idea.

His ramp provides easy access to all eleven levels of parking space, and takes far less room than the conventional ramp. Another feature is that, being centrally located in the building, it can serve entrances on two streets.

The new garage, Dr. Callison finds, takes about 10 per cent of his time. He also owns two medical office buildings and a 75-bed general hospital on Nob Hill. END

Handyman

● The senior class at a large Eastern medical school was listening attentively while a visiting physician delivered a lecture on the local incidence of lead poisoning from paint.

He pointed to a patient under observation—a small, wrinkled man, well into his sixties.

"Notice the lead-line on the patient's gums," said the physician. "Now, if each one of you will step up and examine him . . ."

"Oh, that ain't necessary," munched the old man, as he removed a full set of dentures. "Here, just hand 'em around."

—M.D., CALIFORNIA

Health Questionnaires Aid History-Taking

Here are the facts about standardized forms available, plus some helpful comments from a number of physicians who use them

By Thomas Owens

● Do you invite your patients to fill out a health questionnaire before you begin history-taking and actual examination? If so, you're one of a growing contingent within the profession.

More and more doctors report that such questionnaires provide a quick way of getting part of a medical record of past illness and present symptoms—and on the patient's time, not the physician's. They also make the patient's wait seem shorter if the doctor is a bit behind in his appointment schedule.

The health questionnaire is, of course, an *adjunct* to history-taking, not a substitute for it. What the questionnaire does mainly is to pinpoint symptoms that are—or have been—of most concern to the patient. Given this advance information about possible trouble spots, the medical man can interview the patient with more dispatch and efficiency.

The questionnaires most in use today vary in their details, but are basically alike. Let's take a look at a typical one—the Cornell Medical Index—which is also, perhaps, the most widely used. (Several hundred thousand copies of the Cornell index are sold each year in the U.S.; and it

Bionomy Number 513

(MEN)

CORNELL MEDICAL INDEX

Date May 18, 1955

HEALTH QUESTIONNAIRE

Print Your Name ALEXANDER WEBSTER

Your Home Address ALLERTON, INDIANA

How Old Are You? 48 Circle If You Are . . Single, (Married) Widowed, Separated, Divorced.

Circle the Highest Year You Reached In School | 1 2 3 4 5 6 7 8 | Elementary School | 1 2 3 4 | High | 1 (2) 3 4 | College

What Is Your Occupation? SALES MANAGER

Directions: This questionnaire is for *MEN ONLY.*

If you can answer **YES** to the question asked, put a circle around the (Yes)

If you have to answer **NO** to the question asked, put a circle around the (No)

Answer all questions. If you are not sure, guess.

A

1. Do you need glasses to read? (Yes) No
2. Do you need glasses to see things at a distance? (Yes) No
3. Has your eyesight often blacked out completely? Yes (No)
4. Do your eyes continually blink or water? Yes (No)
5. Do you often have bad pains in your eyes? Yes (No)
6. Are your eyes often red or inflamed? (Yes) No
7. Are you hard of hearing? Yes (No)
8. Have you ever had a bad running ear? Yes (No)
9. Do you have constant noises in your ears? Yes (No)

B

10. Do you have to clear your throat frequently? (Yes) No
11. Do you often feel a choking lump in your throat? Yes (No)
12. Are you often troubled with bad spells of sneezing? (Yes) No
13. Is your nose continually stuffed up? Yes (No)
14. Do you suffer from a constantly running nose? Yes (No)
15. Have you at times had bad nose bleeds? Yes (No)
16. Do you often catch severe colds? (Yes) No
17. Do you frequently suffer from heavy chest colds? Yes (No)
18. When you catch a cold, do you always have to go to bed? Yes (No)
19. Do frequent colds keep you miserable all winter? Yes (No)
20. Do you get hay fever? Yes (No)
21. Do you suffer from asthma? Yes (No)
22. Are you troubled by constant coughing? Yes (No)
23. Have you ever coughed up blood? (Yes) No
24. Do you sometimes have severe soaking sweats at night? (Yes) No
25. Have you ever had a chronic chest condition? Yes (No)
26. Have you ever had T.B. (Tuberculosis)? Yes (No)
27. Did you ever live with anyone who had T.B.? Yes (No)

C

28. Has a doctor ever said your blood pressure was too *high?* (Yes) No
29. Has a doctor ever said your blood pressure was too *low?* Yes (No)
30. Do you have pains in the heart or chest? Yes (No)
31. Are you often bothered by thumping of the heart? (Yes) No
32. Does your heart often race like mad? (Yes) No
33. Do you often have difficulty in breathing? (Yes) No
34. Do you get out of breath long before anyone else? (Yes) No
35. Do you sometimes get out of breath just sitting still? Yes (No)
36. Are your ankles often badly swollen? Yes (No)
37. Do cold hands or feet trouble you even in hot weather? (Yes) No
38. Do you suffer from frequent cramps in your legs? Yes (No)
39. Has a doctor ever said you had heart trouble? (Yes) No
40. Does heart trouble run in your family? (Yes) No

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1300 York Avenue, New York 21, N. Y.

OPEN TO NEXT PAGE

FIRST PAGE of a typical health questionnaire, to be filled in by the patient himself. Apart from six questions in the genito-urinary section of this Cornell Medical Index, the forms for men and women are identical.

has been translated into half a dozen languages.)

The first page of the Cornell questionnaire is reproduced with this article. The complete index has four letter-size pages. It asks 195 questions (in simple, informal English) that correspond closely to what the physician might ask in a detailed preliminary interview.

The questions are of four kinds. They deal with bodily symptoms, past illnesses, family history, and "behavior, mood, or feeling." As you'll see by glancing at the page shown here, related questions are grouped in sections.

Topics Covered

On page one, for instance, sections A, B, and C cover, respectively, the eyes and ears, the respiratory system, and the cardiovascular system. Questions in the other sections deal with the patient's digestive tract, his musculo-skeletal system, skin, nervous system, genito-urinary system, fatigability, frequency of illness, miscellaneous diseases, habits, and mood-and-feeling patterns.

The index is sold on a nonprofit basis by Cornell University Medical College. A package of fifty questionnaires costs $2.50. You can also buy diagnostic sheets—fifty for $1—on which to record your interpretation of the patient's answers.

If you've never tried such questionnaires, you may want to experiment a bit, to find out how best to use them. Most doctors invite the patient to fill one out before his first interview. It takes the average person from ten to thirty minutes to circle the answers to the questions.

How to Use Them

If there's time, the form can be mailed to the patient at home. More often, it's simply handed to him in the reception room.

But not all M.D.s regard this as the best procedure. A Newark, N.J., internist, for example, tells me he always conducts a preliminary interview, then hands the patient the questionnaire and tells him to bring it back, completed, on his next visit to the office.

"I feel an initial interview is necessary to establish rapport," this man explains. "A new patient might well be taken aback if my aide popped a four-page form into his hand as soon as he stepped inside the office."

'Yes' Gives a Key

In any case, the doctor usually studies the completed questionnaire for a few minutes before having the patient ushered in for his interview. Then he devotes further questioning mostly to the "Yes" responses, and thus shortens the time spent in history-taking.

Of course, the time-saving benefit is only one of several. I've asked quite a few doctors who use health questionnaires just how they find them helpful. Here's a sampling of their replies:

¶ "Such a questionnaire is of great value to the physician who practices alone," says a Springfield, Ill., G.P. "I find it gives me an excellent review of symptoms of the body systems."

Diagnostic Use

¶ Says a Dallas internist: "The Cornell index has helped me make correct diagnoses on cases that had been misdiagnosed at university hospital-clinics. Without it I'd have a much lower batting average than I have at present."

¶ A Chicago specialist studies with great interest the answers to questions that deal with the patient's psychosomatic problems. "They help the physician evaluate the organic complaints that the patient has enumerated previously," he explains.

Even to Old-Timers?

Some M.D.s give the questionnaires only to the patient who comes in for a general check-up and who has no specific complaint. Others say they find them useful with all—or nearly all—new patients. A Los Angeles M.D. goes even further: "When a regular patient whom I haven't seen for over a year comes in, I have him fill out a new questionnaire. The comparative answers are of considerable diagnostic value."

Is there anything to be said *against* the questionnaire procedure? Well, the forms do cost money; and some doctors feel they're not worth the extra expense and the extra effort.

Says a Boston practitioner who has given up using them: "As far as I'm concerned, they've proved totally unsuitable for private practice, though they may be useful for cataloguing certain medical research projects."

Some M.D.s Disagree

Adds a physician in Muskegon, Mich.: "A questionnaire can only reveal symptoms that the patient is aware of. You still have to do standard laboratory and physical examinations, to discover the asymptomatic diseases."

And a St. Louis man warns that "questionnaire-doctors can easily fall into the mistake of putting practice on an assembly-line basis."

Perhaps the best way to test such objections is to ask a basic question: What do *patients* think of the system? The answer: They seem to like it when it's handled right.

Says a Duluth, Minn., G.P.: "I've found that patients feel reassured about the thoroughness of an examination if it's preceded by a questionnaire."

A San Francisco neurologist reports that people who are tense and fearful of disease often feel better after going through the 195 questions of the Cornell Medical Index. "They're usually relieved to see the large number of 'No' answers," he concludes. END

First Report on
Polio Vaccine Fees

By Mauri Edwards

Less than a month after the big anti-polio drive had been launched, most doctors seemed to have their fee and priority problems under control. But with vaccine still in short supply, a clamor was building up for the Government to take over. For exclusive bulletins from seventeen key areas, see the following pages

REPORT ON POLIO VACCINE FEES

● If you scanned your newspapers around the start of May, you got the impression that Salk Season was off to a poor start. Glaring headlines told you that confusion, shortages, and double-dealing were abroad in the land.

But if you were among the many thousands of doctors on the immunization firing line, you probably wondered what all the shouting was about. For the simple fact is that the first weeks of the 1955 anti-polio drive were anything but a complete bust. By the beginning of May, when this edition of MEDICAL ECONOMICS went to press, the free-inoculation program of the National Foundation for Infantile Paralysis had already rolled through almost half its first round of school shots. And the typical physician not only had taken part in the big needling; he'd also soothed the anxious mothers on his private list, and he'd agreed to keep his fees down for all comers.

This broad picture of orderly professional planning emerges from a spot check made by MEDICAL ECONOMICS just before press time. Here are some specific reports received from key areas at the start of May:

ATLANTA, GA.—By May 1, all but 11,000 of Georgia's 211,000 first- and second-grade school children had received their first free shots; and doctors were readying their needles for round two.

Private physicians were preparing lengthy waiting lists against the expected arrival of commercial vaccine. In Atlanta, they planned to charge $5 a shot (the cost of the vaccine included); and it appeared that fees elsewhere in the Southeast would run close to that figure. "Maybe $5 seems a little high," said one leading Atlanta pediatrician. "I charge just $3 for most shots; but this vaccine costs us more than the others."

This magazine's correspondent in Atlanta concluded her report by stating: "There hasn't been a hint of hoarding or black-marketeering here."

LANSING, MICH.—At first, it was uncertain just what Michigan doctors would charge. Detroit M.D.s wanted to set fees at $6 per inoculation. Others favored a $5 fee. But about a week after the Salk vaccine's Ann Arbor approval, the state society called on its members to hold fees way down. The society recommended a charge of $2 plus the cost of the vaccine—a total of no more than $4 per shot.

HOUSTON, TEX.—Since polio was expected early in the Southwest, Texas doctors were among the first to inoculate youngsters in school. Private vaccinations hadn't yet started at the beginning of May; but doctors generally felt that $5 would be a fair fee.

SEATTLE, WASH.—Despite some confusion, Washington physicians

appeared ready, at the start of May, to handle Salk shots—in the schools and privately—when the vaccine arrived. Announced fees ranged from $10 to $15 for a three-shot series. A few doctors said that they'd give inoculations on a cost-only basis.

DES MOINES, IOWA—No attempt was made in Iowa to set fees for commercial vaccine. But the prevalent attitude early last month was that $4 to $5 would be a fair fee for an inoculation. Some doctors were already charging that amount as a little vaccine for private patients became available to them.

INDIANAPOLIS, IND.—Vaccine fee setting was left to Indiana's county societies, which were recommending that doctors charge between $12 and $15 for a full series of three shots. The state society, meantime, planned to establish a special committee to deal with distribution problems.

WASHINGTON, D.C.—Doctors in the capital agreed to charge patients the cost of the vaccine plus "a reasonable amount for their services." It appeared that this amount would range from $2 to $3, bringing the cost of an inoculation to about $4 or $5.

LINCOLN, NEB.—Across Nebraska, which has had the worst polio rate in the U.S. over the last five years, almost all first and second graders had been given their initial Salk injections by early May. Except in isolated cases, these shots were free.

Almost no commercial vaccine was available to Nebraska physicians. But it appeared that when they were able to begin giving private inoculations, they'd charge regular office-call fees *plus* the cost of the vaccine. Average fee: about $5.

BILLINGS, MONT.—Doctors in Montana planned to charge from $8 to $12 for a complete three-shot course of Salk vaccine. Virtually no commercial vaccine had shown up in the state, however, by the beginning of May.

NEW YORK CITY—Dr. Peter Marshall Murray, president of the New York County medical society, urged local physicians to provide vaccine "for reasonable fees and where possible for reduced fees." It seemed likely, early in May, that the average fee for Salk shots given in the metropolitan area would be $5.

ST. PAUL, MINN.—No recommendations were made to Minnesota doctors about charging their private patients for anti-polio shots. But medical men in some counties were making charges of up to $1 per shot for their work in the National Foundation's school program. County societies explained that the fees covered the cost of needles, syringes, and sterilizers. [MORE ▶

SAN FRANCISCO, CALIF.—No effort was made to set vaccine fees in California. But it appeared in early May that $15 would be the usual fee for a three-shot Salk course.

PORTLAND, ORE.—No single fee applied to all of Oregon at the start of May. Some local medical societies urged their members to charge $10 for a full set of three shots. But Portland doctors seemed to favor fees ranging from $12.50 to $15 for the full series.

The National Foundation program, known in Oregon as "Operation Needlepoint," was hanging fire. But some commercial vaccine had sifted into the state—enough for close to 2,000 shots, according to one estimate.

MADISON, WIS.—Fees for private inoculations of vaccine were left up to the individual doctors in Wisconsin. It seemed likely, as of early May, that the average charge would be about $5 per shot. A small quantity of commercial vaccine reached the state at the very start of the Salk campaign.

JACKSON, MISS.—G.P.s and pediatricians in Mississippi planned to charge from $10 to $12 for a three-shot course of vaccine. At the start of May, though, virtually no commercial vaccine was available.

BOSTON, MASS.—As far as fees were concerned, Massachusetts medical men were left on their own. It seemed probable that the average fee would be $5 per inoculation. However, the state medical society assured the public that "everyone who needs vaccine will get it regardless of ability to pay."

HARRISBURG, PA.—Doctors in some Pennsylvania counties agreed to charge about $5 per Salk shot. As of the beginning of May, however, few private vaccinations had been given.

$4-$5 Average

When you put these reports together, what do you get? A national average polio-shot fee of roughly $4 to $5, including the cost of the vaccine. But even more important, you see that when May came, the typical doctor was facing up to his responsibility. Yet the pressure for Federal controls was mounting.

A climax came Monday morning, May 2, when the free-enterprising, anti-Big-Government New York Herald Tribune appeared on the street with an editorial staring at readers from an unusual vantage point: the top of the front page. WASHINGTON MUST ACT, proclaimed a bold, black headline.

In equally positive terms, the editorial began: "The Salk vaccine against poliomyelitis is a national blessing which has created a national emergency. Experts have confirmed the vaccine's general efficacy. The demand is far greater than

the supply. Every child in America has a right to its protection.

"The serum can only be, and must be, controlled nationally."

Weren't the established distribution plans good enough? Not for the Herald Tribune, they weren't. The editorial said:

Voluntary Ways Opposed

"The fear of polio has haunted parents for generations. It is too much to expect of human nature that when the promise of release from that fear appears, voluntary arrangements will hold against a mother's insistence on the protection of her children or the greed of those who want to make money out of that emotion. New Yorkers remember the near riots that were produced by the distribution of gamma globulin, far less effective than the Salk vaccine. They are aware that already supplies of the new serum have disappeared into unauthorized channels and been diverted to adults when the moral right of children to priority is unchallenged.

"To bring order out of this explosive situation, a national law is essential."

So saying, the Herald Tribune called for a law that would:

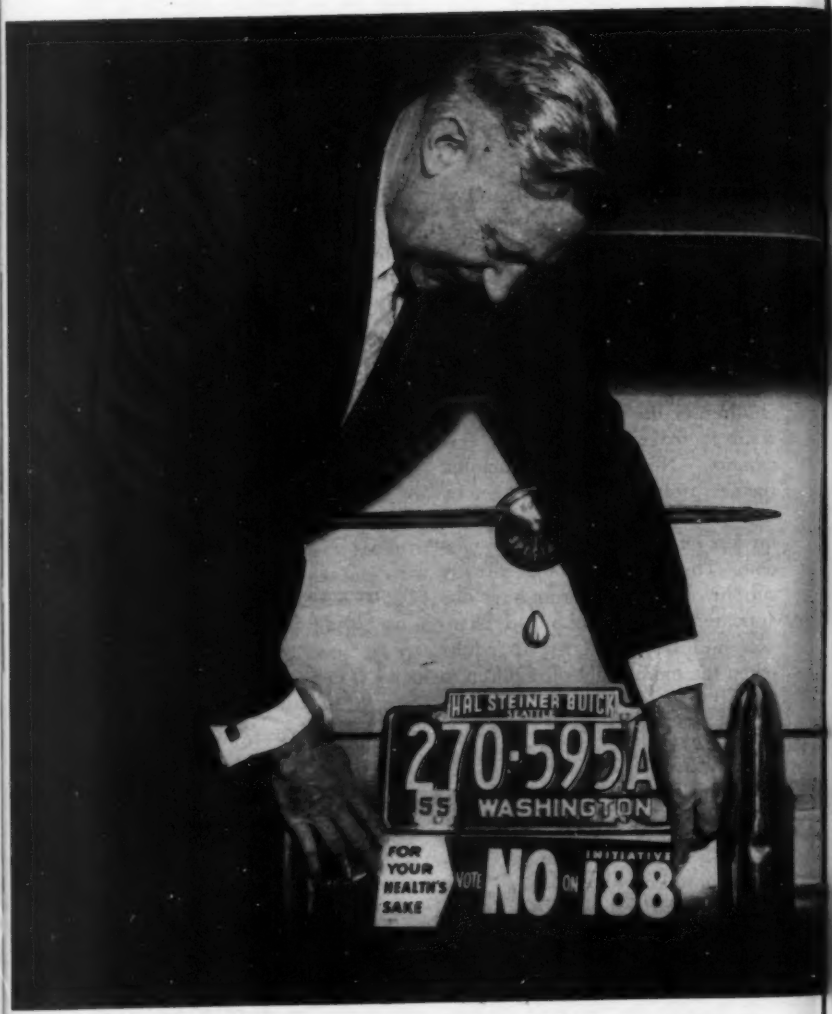
1. Give the Government complete control over the vaccine "from producing laboratory to the person receiving the injection," with power to set prices, allocations, and priorities.

2. Provide for "prompt dissemination of fully evaluated information on all medical aspects of the program," as insurance against hysteria.

3. Establish "harsh" penalties for wrongdoers.

Response was instantaneous and concrete. Senator Irving Ives (R., N.Y.) introduced a bill neatly tailored along Herald Tribune lines. A dozen other lawmakers—on both sides of the aisle—signed on as cosponsors. Two similar bills appeared in the House of Representatives. And even so fervent a foe of Government intervention as Minority Leader Joseph W. Martin Jr. announced: "It is important for the Government to con- [MORE ON 243]




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WASHINGTON
FOR YOUR HEALTH'S SAKE
VOTE NO ON INITIATIVE 188

It Takes Planning To Beat the Chiropractors

These Washington State physicians won at the polls for a compelling reason: They left nothing to chance. Here's the story—with pictures—of their carefully engineered campaign

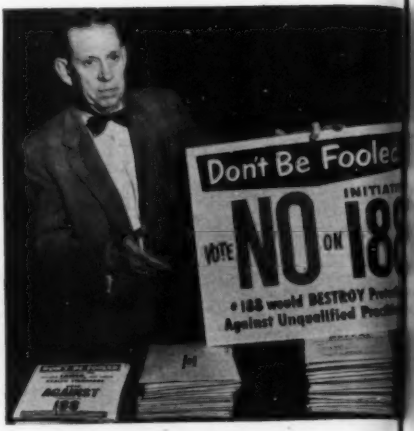
By John R. Lindsey

● More than one medical man has blown his top over the legislative complots of the chiropractors. So a rise in the collective blood pressure of Washington State's 2,700 M.D.s when they first heard of Initiative 188 last year would not have been surprising. For this chiropractic bill was contrived with the express aims of (1) lowering the minumum passing grades required in each of the state's basic science examinations (from 70 to 60) and (2) setting up a new chiropractic licensing board that would examine chiropractors in their own version of the basic sciences.

Yet actually not a top *was* blown. Instead, Washington's physicians calmly organized a state-wide counter-offensive.

MORE ▶

25,000 AUTO BUMPER STRIPS like this one played a part in the state-wide campaign by Washington's 2,700 physicians against the chiropractors' Initiative 188. Shown fastening a strip to the rear of his car is Dr. Frank H. Douglass of Seattle, who headed the local campaign in the state's largest county.



THE PHYSICIANS' CHOICE to lead their fight against the chiropractors' bill for lowering health standards was Dr. A. J. Bowles of Seattle, pictured here with one of the campaign posters. Dr. Bowles was chairman of the Washington State Medical Association's public relations committee, which directed the doctors' campaign. He also was co-chairman of the Washington State Committee to Protect Health Standards, made up of physicians and laymen.

Profiting by past mistakes, they covered every angle, overlooked no detail. The result was a campaign so decisively effective that it offers an example to doctors everywhere.

Dr. M. Shelby Jared, president of the Washington State Medical Association, and Dr. A. G. Young, his predecessor, helped spark the drive. "We determined at the outset," says Dr. Young, "not to be drawn into a squabble over the philosophies of the healing arts. Instead, we made clear to the voters that the only issue was one of health standards. We urged everyone to vote for his own health's sake."

The medical men moved swiftly. In almost every one of the thirty-nine counties they set up a Committee to Protect Health Standards, headed by a physician and by a prominent layman. Co-chairmen for the state were Dr. A. J. Bowles, the medical association's public relations chairman, and Harry L. Given, a Seattle insurance executive and popular amateur golfer.

Osteopaths Join In

The M.D.s joined hands with the osteopaths, the dentists, the nurses, the pharmacists, the veterinarians, and the Washington State Health Council. They campaigned in meeting halls, on the radio, and on TV. They addressed parent-teacher groups; women's clubs; granges; labor unions; and veterans, civic, service, and fraternal groups. They drafted pamphlets, newspaper ads, placards, and posters. They set up



THE DOCTORS' ARSENAL of weapons used in their campaign to kill Initiative 188 included pamphlets, postcards, posters, stamps for doctor bills, and speakers' kits. The figures above represent the numbers of these campaign materials distributed in the State of Washington. Newspaper stories [▼] gave a running account of the physicians' winning fight against the chiropractors' bill. The headlines suggest the extent of the support the medical men got from osteopaths, chiropodists, veterinarians, dentists, nurses, and others.



speakers' bureaus throughout the state.

More than 1 million postcards were mailed out over the personal signatures of physicians and their supporters. Hundreds of kits were made up for campaign workers—each kit containing sample news releases for press and radio, a suggested model for a letter to the editor, editorial ideas, and sample speeches varying in length.

Physicians' wives worked with women's groups in distributing literature, organizing rallies, and addressing meetings. They helped doctors paste on their statements and other mail more than 1½ million stamps that said, "For your health's sake, vote against Initiative 188." They got out the vote.

Result of this manifold effort: The chiropractic bill was buried. Final vote: 493,108 to 320,179. END

Off on a Tear

● I was hunting with some friends in the hinterlands of Tunisia when an Arab galloped up and asked if there was a doctor in our party. I stepped forward and put myself at his service.

"Excellency, my wife dies," said the Arab. "Please come quickly."

I did. I examined the woman. I told her husband she had pneumonia and ought to be taken to a hospital in Tunis.

Before I left, the Arab implored me to write a prescription. "All right," I said, handing him one. "Give her some of this every hour. But get her to the hospital promptly."

Some time later I returned to the same region. My Arab friend greeted me with smiles and salaams. He said his wife was completely cured.

"You took her to the hospital?" I asked.

"Oh no, Excellency," he said. "It was the magic of your writing."

"You mean my prescription?"

"Yes, Wonder-Worker," he replied. "I tore it in pieces and gave her some every hour, as you advised."

—LUDWIG C. KALNIN, M.D.

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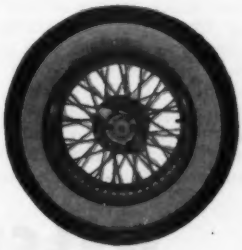
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What Makes a Fee 'Fair'?

A symposium on how to evaluate the M.D.'s services, how to handle the patient who resists the fee, and how to judge colleagues' charges

By Wallace Croatman

● How can a physician justify a substantial fee in a nonsurgical case?

How should he set charges for follow-up visits?

How much—if at all—ought he to reduce a fee if the patient complains that it's too high?

Recently MEDICAL ECONOMICS put these and other fee questions to a selection of doctors in each state. This was not a stratified sampling but an attempt to sound out opinion among men best informed on the issue. Many of them are chairmen of mediation committees of county or state medical societies.

The questions asked were an outgrowth of an article that this magazine published some months ago, in the form of a series of letters.* The letters had to do with a fee dispute that actually occured between a doctor whom we called John Smith and his patient, Harry Green; and they were printed exactly as written, except for the necessary disguising of identities. (For a brief review of the case, see page 153.)

There was a high degree of unanimity in what the grievance committee chairmen had to say. An overwhelming percentage of them seemed to feel that in setting fees the physician ought to:

*"Fee Complaint (a case history)," January, 1955.

1. Discuss the fee with the patient in advance;

2. Charge for follow-up treatments as they occur—not in advance; and

3. Beware of offering to reduce a fee once set, unless there's clear-cut evidence of the patient's inability to pay.

True, these are fairly elementary points. Yet according to the medical leaders heard from, they're important enough to bear repeating, if only because so many practicing physicians, like John Smith, continue to overlook them.

Rank and File Dissent

It's interesting to compare the reaction of the grievance committee chairmen with that of the other doctors questioned. Most of the committee chairmen are critical of Dr. Smith; they say his fee-setting methods are too arbitrary. But among the rank and file, this sentiment appears less strong; indeed, several physicians maintain testily that a doctor's fee-setting methods are—and should be—his own concern, and no one else's.

A Virginia G.P. submits an especially impassioned argument for what he terms "unusual charges for unusual services." Says he: "The doctor must realize that, except for sentiment and lip service, the public has little respect for his dedication, altruism, or contribution to the welfare of humanity. It does not hesitate to exploit him for its own selfish ends." So—this G. P. implies—the physician may justifiably go and do likewise.

Of course, there *are* times, he admits, when patients *do* come to an understanding of what their doctor has done for them. It's then that they willingly pay high fees for relatively simple procedures. "And why not?" he asks, citing two cases from his own experience to bolster his point:

No Divorce Needed

"Mr. and Mrs. X, married six months, consulted me for the not unusual complaint of sexual maladjustment. Divorce was in the air. She had consulted one gynecologist after another; and he had been to several urologists. Both had been told that they were normal physically and that they'd better go home, kiss and make up, and wait for Father Time to solve their problem.

"My only finding at first was that the wife's vaginal canal was a bit narrow and that the cervix was smaller than normal. I then looked to see why the vagina had such a small lumen and did not balloon out where it reached the cervix. I found that she had a double vagina with the septum pushed to one side, so that it could neither be seen nor felt. Examination of the adjacent vagina disclosed another cervix.

"I resected the septum—which took only a few minutes—and the couple went away elated.

"Believing that an unusual diag-

Highlights of the Smith-Green Dispute

Nov. 2, 1953: Dr. John Smith bills Patient Harry Green $250 for "examination and injection treatment of hemorrhoids (including all treatments necessary to September 1, 1954)."

Nov. 16, 1953: Mr. Green writes that the charge "seems excessive to me. I think I was in your office about ten times and that makes the visits $25 each."

Nov. 18, 1953: Dr. Smith to Mr. Green: "If you feel I have overcharged you, I shall be glad to deduct 20% from my bill if you want to send a check before December 1."

Nov. 24, 1953: Green objects to the doctor's "willingness to give me further treatments without charge until September 1, 1954 . . . If I want the insurance involved in your method of charging, I would cover it by an insurance policy." He offers to submit the grievance to the county medical society, and to abide by its decision.

Feb. 11, 1954: Green submits his complaint to the New State Medical Society, which forwards the correspondence to the Bigtown County Medical Association.

Sept. 30, 1954: In a letter to the county society, Green says he has heard nothing about his case since February; "and only yesterday I received another bill for $250 from Dr. Smith."

Oct. 11, 1954: The county society notifies Green that "on May 21, 1954, the [county society's] Board of Governors [upheld] the fairness of the fees charged Mr. Green by Dr. Smith."

Nov. 23, 1954: Following Green's appeal to the New State Medical Society, its Committee on Professional Relations rules "that the charges made by Dr. Smith . . .were excessive and that a fair charge would have been $25 for the first visit and $10 each for subsequent visits, a total of $125." It also deplores the manner in which the local association handled the case.

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NEW YORK 10

nostic service had been rendered, I sent a bill for $250. They paid the bill at once. When Mrs. X later became pregnant in the right uterus, her confidence in me was such that she insisted I deliver the baby, even though she knew I had long since given up obstetrics.

He Saves a Finger

"Another time," the Virginia G.P. says, "a 14-year-old boy was brought to my office with a severely infected right index finger. The history showed that a crushing injury had occurred eight weeks before. Since then he had been treated by his family physician and by a surgeon and two orthopedists.

"The entire distal end of the finger was affected, with pus oozing from an incision just medial to the nail. The nail itself was loose, and the surrounding skin was swollen and red. X-ray showed that the entire interior of the phalanx had been destroyed, leaving only a shell.

"All four men consulted had recommended that the finger be amputated at once. But the boy was



"Gee, Mom, it's lucky you were here when it happened!"

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REFERENCE: 1. Kirwin, T. J., Lowsley, O. S., and Menning, J.: Am. J. Surg. **62**:330-335, December, 1943.

studying music, and so had a special reason for wanting to keep his finger. I told his father I could make no promises, but I'd do my best to save it.

"After removing the nail, which came away easily, I passed a curette into the phalanx and brought out several sequestra that had apparently been hanging to the remaining bone. The purulent discharge decreased by almost half, and the pain diminished considerably. Later I removed another sequestrum and the discharge stopped.

"In time, the finger healed completely. While the distal interphalangeal joint didn't recover its full range of motion, the boy was able to continue his musical studies.

"There was no operation—only five short office visits. But I sent a bill for $100; and the father paid it the day he got it."

'No Risk Involved'

Since the two cases cited were unusual ones, they may well have merited higher-than-ordinary charges. But as far as the Smith-Green case is concerned, most of the doctors surveyed say the original fee of $250 was far too steep for the service given.

"Injection treatment of hemorrhoids is actually a rather routine office procedure," one mediation committee chairman says. "The risk and work simply don't justify such a bill."

Apart from the exorbitance of his charges, Dr. Smith made several other errors, say the grievance committee chairmen. A Californian puts it this way: "Smith did not discuss the charge prior to the treatment. He did not itemize his statement once the services were rendered. Nor did he bill the patient as promptly as he should have. Moreover, to include a year's aftercare in a parenthetical remark in the statement seems ridiculous."

Unfortunately, this physician adds, "Smith's mistakes are all too common among the profession at large."

Advance Talk a Must

If publication of the Smith-Green story did nothing else, several doctors say, it should at least have underscored the importance of discussing fees with patients in advance. Dr. H. W. Fuller, who heads the mediation committee of the Montana State Medical Association, sums up a widespread view:

"The large majority of fee complaints with which I have been involved would have been avoided if the doctor had discussed the matter of the fee with the patient *before* the patient received a bill for which he was unprepared."

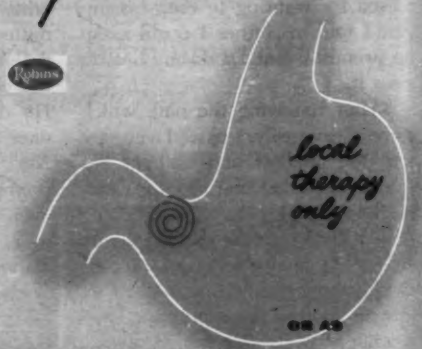
Dr. Paul R. Hawley (speaking for himself, rather than as director of the American College of Surgeons) carries this argument a step further. It's his personal opinion that "if the patient is not aware of the charge until after the service is

for peptic ulcer

ROBALATE®

provides two-way protection, with an antacid-demulcent action superior in many ways to that of dried aluminum hydroxide gel. It is 42% more efficient in acid-consuming power[2]...more rapid in its neutralizing action[1]...is not inhibited by pepsin[3]...does not disturb bowel activity[4] ...and its effectiveness is not diminished by age.[3]

Each tablet contains:
Dihydroxy aluminum aminoacetate....0.5 Gm.



OR AS EACH CASE MAY REQUIRE

- blocks acid erosion
- blocks local irritation
- blocks a hyperactive vagus
- blocks emotional tension

DONNALATE®

provides four-way protection, with Robalate's superior antacid-demulcent action, plus Donnatal's recognized spasmolytic-sedative effectiveness.

Each tablet contains:

Dihydroxy aluminum aminoacetate	0.5 Gm.
Hyoscyamine sulfate	0.052 mg.
Atropine sulfate	0.010 mg.
Hyoscine hydrobromide	0.003 mg.
Phenobarbital (¼ gr.)	8.1 mg.

(Each Donnalate tablet =
1 Robalate tablet + ½ Donnatal tablet)



Both Robalate and Donnalate are *free from grittiness* and the chalky feeling usually associated with many antacids...*free from side effects*, such as systemic alkalosis and disturbance of bowel activity.

DOSAGE: 1 or 2 tablets after each meal and before retiring, or as directed.

SUPPLY: Bottles of 100 and 500 white (Robalate) or yellow (Donnalate) tablets.

REFERENCES: 1. Hemmerhard, E. R., Rising, L. W., J. Am. Pharm. Assn. (Sci. Ed.), 38:286, 1949. 2. Krantz, J. C. Jr., et al., J. Pharmacol. Exper. Therap. 82:247, 1944. 3. Murphey, E. S., J. Amer. Pharm. Assn. 41:361, 1952. 4. Bosling, J. E., et al., Rev. Gastroenterol, 16:686, 1949.

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rendered, he has both a legal and a moral right to object to the size of the fee."

Another physician points out that if there's no advance agreement to the contrary in an office-visit case, "the patient has a right to assume that he's paying only office-visit fees."

Justifying the Fee

How to justify a fee that strikes the patient as too high? One of the best ways, obviously, is to be able to show that your charges are in line with what other local physicians get for similar services. So there's a good deal of sentiment for fee schedules, set up by medical societies.

But it's also true that many doctors vigorously oppose such schedules. They say they interfere with the M.D.'s freedom to decide the value of his own services.

There's similar disagreement on the factors the doctor should consider in setting a fee. Some mediation committee chairmen claim that all patients should be charged alike for the same [MORE ON 252]



"Are you deductible?"

Why Some Doctors Never Admit They're Sick

They advise against giving the gossips a chance to talk small headaches into big brain tumors

By Charles Price, M.D.

● I hear Dr. X has just died. He strove for years to become superintendent of the local hospital. And he finally made it. Now, two weeks later, his sudden death—a complete surprise to almost everyone.

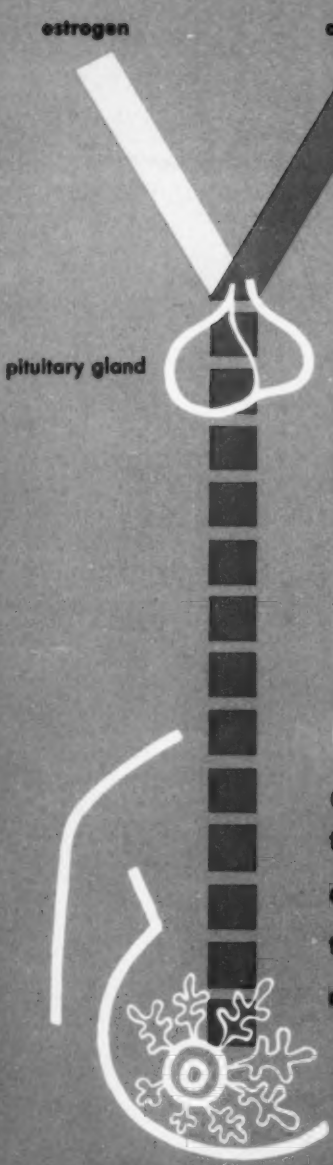
There's one consolation at least: his widow will have a pension computed on the basis of his salary as superintendent, rather than on his former (and much lower) pay as section chief.

I can't help thinking about a piece of strange advice Dr. X gave me fifteen years ago. At that time, I was a junior ward doctor under him. Driving to a meeting, I mentioned that I'd recently had an attack of simple tachycardia—a meaningless symptom, of course, due probably to too much smoking. (I've had no trouble since.)

Dr. X said to me, "Let me give you a tip: Never, *never* admit that you have had any illness or disability—ever!"

The remark seemed odd. So I asked what he meant.

"Well," he said, "let me tell you confidentially that you're being considered for the position of chief of the reception service. Now suppose that, on hearing of your tachycardia, I figured you must have had a real heart attack. I'd wonder if it were a good idea to give you that demanding job. By the time the story got to the



for the relief of

postpartum breast engorgement

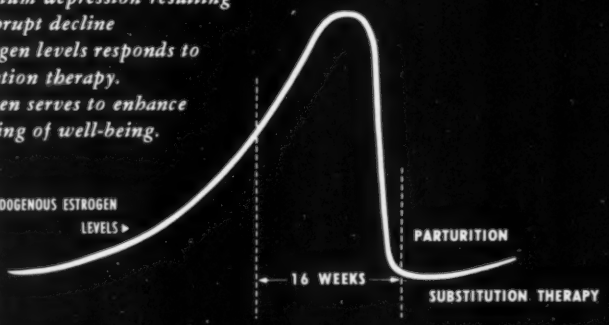
(when lactation is to be suppressed)

the complementary action of combined estrogen-androgen therapy is greater than the effect of either steroid employed alone

Postpartum depression is notably absent

In 96.2 per cent of a series of 267 patients in whom postpartum breast engorgement was effectively suppressed by "Premarin" with Methyltestosterone, Fiskio[1] noted as a particular advantage the absence of mental depression usually occurring on the fourth or fifth day of the puerperium.

Postpartum depression resulting from abrupt decline in estrogen levels responds to substitution therapy. Androgen serves to enhance the feeling of well-being.



SUGGESTED DOSAGES

Some clinicians recommend intensive short duration therapy while others advocate lower dosage levels extending over a longer period of time. In either case, it is important to start therapy as soon as possible after delivery.

Short duration therapy (one week)

3 tablets (yellow) every four hours for five doses; then 2 tablets daily for balance of week.

"Step-down" therapy (10 to 15 days)

1st day—4 tablets (yellow) in divided doses;
2nd day—3 tablets (yellow) in divided doses;
3rd day—2 tablets (yellow) in divided doses;
subsequently—1 tablet (yellow) daily.
Treatment is continued for 10 to 15 days.

Dual steroid therapy effectively relieves the discomfort of postpartum breast engorgement with virtually none of the side effects likely to occur with estrogen or androgen alone.

"Premarin" with Methyltestosterone effectively inhibits lactation and "seems to have small capacity to induce withdrawal bleeding, the most dangerous side-effect of the usual lactation-inhibiting drugs."[2]

Many clinicians favor the use of estrogen and androgen as combined in "Premarin" with Methyltestosterone,

1) because of the additive effect of the two steroids in inhibiting the pituitary lactogenic hormone,

2) because therapeutic control is usually achieved without undesirable side effects such as nausea and vomiting, excessive lochia, withdrawal bleeding, recurrence of engorgement, and virilization.

1. Fiskio, P. W.: Personal communication.
2. Wilson, T. M.: M. Ann. District of Columbia *23*:489 (Sept.) 1954.

Ayerst Laboratories • New York, N. Y. • Montreal, Canada



Most encouraging results obtained with "Premarin" with Methyltestosterone in suppression of postpartum breast engorgement.

Wilson reports that in 23 patients "treated for the five days postpartum, 18 (78 per cent) had excellent results with suppression and absence of engorgement, and 5 (22 per cent) had good results. There were no failures."[3] For further details on therapy, see preceding page.

Other Indications

"Premarin" with Methyltestosterone is also indicated in osteoporosis, dysmenorrhea, climacteric (female and male) in certain cases, malnutrition (in the female), and as an adjunct to treatment with cortisone in rheumatoid arthritis.

SUPPLIED IN TWO POTENCIES: the *yellow* tablet (No. 879) contains 1.25 mg. of conjugated estrogens (equine) and 10 mg. of methyltestosterone; the *red* tablet (No. 878) contains 0.625 mg. and 5 mg. respectively. Both potencies are available in bottles of 100 and 1,000 tablets.

"PREMARIN"® with METHYLTESTOSTERONE

ideal preparation for combined estrogen-androgen therapy

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hospital board, they'd be spreading the rumor that you'd had a coronary. Then, if you took a ten-day vacation to hunt in the Ozarks, the gossips would say, 'Hm-m. He must have gone to the Mayo Clinic!' "

Advice Proves Good

I passed his advice off at first as one of those homilies that seniors are forever wishing on juniors. But before the year was up, I'd begun to wonder. Several things had happened that made me think of what he'd said. For example:

A local physician was invited to give a series of lectures to members of the police and fire departments. He was too lazy to write them up, too polite to say no, and too shy to say he was busy. So he told them he hadn't been feeling well and thought he should spend his evenings quietly at home.

The story spread, growing with each repetition. By the time I heard it, people were saying:

"Poor Dr. Smith. He ain't what he used to be."

"Wonderful fellow, but I hear he isn't well enough to make calls."

Buzz, buzz, buzz . . .

Then there was Dr. Brown. Dr. Brown had sciatica. At least, if *I'd* had it, it would have been sciatica. But nothing would do for him but to call it by the nice, fancy name of Guillain-Barré syndrome.

Trouble is, some neurologists think Guillain-Barré is a form of myelitis. As a result, we soon heard that the doctor had encephalitis; and before long this became an "ascending paralysis." The victim would have been better off limping around in grim silence.

Following the Smith and Brown incidents, I ran into Dr. X and reminded him of his earlier warning.

"Now you see what I meant," he said. "The thing to do is grin and bear it. If someone notices you limping, say you slipped on the ice and bruised your backside. Minimize it, son! If you don't, they'll maximize it; and, for a doctor, that's bad. He has to be a walking advertisement for good health."

° ° °

True to form, Dr. X took his own advice. He knew last summer he had carcinoma of the lung; for I read the X-rays and I told him. I felt I must. He had preparations to make.

And he did prepare. Somehow he kept down the coughing, passed off the loss of weight, explained away the hoarseness, and kept up such a good front that the hospital board made him superintendent when *he* knew he was about to die. To the board, he was a man who'd never had a day's sickness.

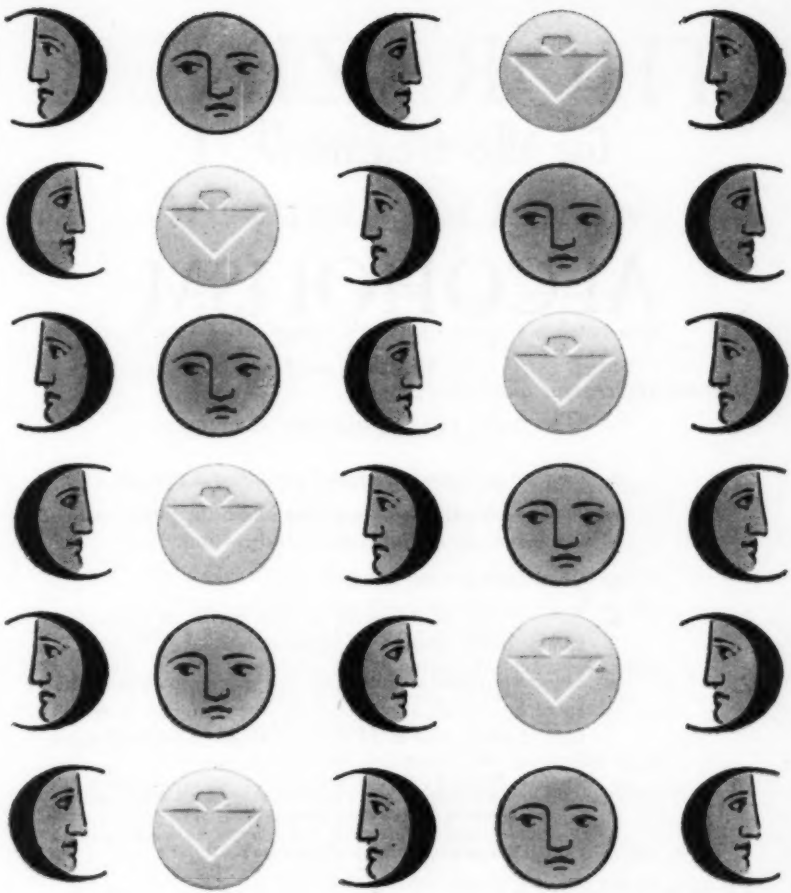
It seems to me he proved the good sense of his own advice. I know other doctors who follow the same policy. They simply never talk about their ill health, even as a joke.

I believe they're right. Don't you?

END

ERIK NITSCHE

repeated tests prove faster pain relief with Anacin



Tests, recently completed on a significant number of patients, again prove Anacin to be a faster acting analgesic than either aspirin or a buffered type aspirin. Patients who received Anacin revealed the presence of the main metabolite of phenacetin in the bloodstream minutes before any salicylates could be detected. Results were confirmed in subsequent tests. The type of quick, dependable relief that Anacin provides is available to your patients who may obtain Anacin at the nearest pharmacy.

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WHITEHALL PHARMACAL COMPANY, NEW YORK, N. Y.

THORAZINE*

for the treatment of

ALCOHOLISM

In acute and chronic alcoholism,
'Thorazine' has the following advantages:

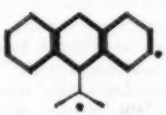
- Controls psychomotor agitation and delirium tremens
- Induces relaxation and sleep from which the patient can be aroused to take food or fluids
- Controls nausea and vomiting
- Restores appetite and ability to take liquids; in many cases eliminates the necessity for intravenous fluids
- Lessens or abolishes the anxiety and tension so often experienced by chronic alcoholics; helps these patients to refrain from drinking and to be more receptive to psychotherapy

1. *Albert, S.N.; Rea, E.L.; Duvernoy, C.A.; Shea, J., and Fazekas, J.F.: Use of Chlorpromazine in the Treatment of Acute Alcoholism, M. Ann. District of Columbia 23:245 (May) 1954.*
2. *Cummins, J.F., and Friend, D.G.: Use of Chlorpromazine in Chronic Alcoholics, Am. J. M. Sc. 227:561 (May) 1954.*

'Thorazine' Hydrochloride is available in 10 mg., 25 mg., 50 mg., and 100 mg. tablets; 25 mg. (1 cc.) ampuls and 50 mg. (2 cc.) ampuls; and syrup (10 mg./5 cc.).

For information write:

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1530 Spring Garden Street, Philadelphia 1



★T.M. Reg. U.S. Pat. Off. for S.K.F.'s brand of chlorpromazine.
Chemically it is 10-(3-dimethylaminopropyl)-2-chlorphenothiazine.

Penny Stocks Are Strictly for Laughs

For only 50 cents a share, you can invest in Whatzis Uranium. But this article explains why you'd do nearly as well out at the race track

By Morton Yarmon

● The penny stock is blood brother to the daily double at Belmont and the slot machines in the locker room at your golf club—with this big difference:

Everyone agrees that the ponies and the one-armed bandits are gambles, pure and simple; but some otherwise smart people insist on taking penny stocks seriously.

For the most part, they're wrong. To understand why, let's ask—and answer—some basic questions:

1. *Just what is a penny stock?*

You won't find a fixed definition in Webster. But what most people take a penny stock to mean is a highly speculative issue that sells at less than a dollar a share.

What happens if the stock shoots up in value over the dollar mark? Investment specialists *still* call it a penny stock; for once a penny stock, they argue, *always* a penny stock.

2. *In which industries do you find penny stocks?*

Most of them are in industries that exploit the riches

MR. YARMON *is a frequent contributor on financial subjects to national magazines. He is also co-author of "Put Your Money to Work for You," a recent book-length analysis of investment techniques.*

Areas of Clinical Study / One of a series

ANEMIA OF PREGNANCY

Maintenance of normal blood values during pregnancy is a factor in the welfare of the mother at delivery and in preventing anemia in the infant. Improvement in the patient's vitality and emotional stability during gestation can also be achieved.

RONCOVITE, *the original, clinically proved cobalt-iron product, has introduced a wholly new concept in the prevention and treatment of anemia. It is based on the unique hemopoietic stimulation produced only by cobalt. The application of this new concept routinely in pregnancy practically insures against the development of iron-deficiency; its use has also led to marked, dramatic advances in the successful treatment of many of the anemias.*

In a recent clinical study of anemia in pregnancy, Holly[1] *reports:*

—about 80 per cent of normal patients manifest significant decreases in hematologic values during pregnancy.

—conversely, 90 per cent of pregnant women maintained hemoglobin levels of 12 Gm. per cent or over when given Roncovite (iron-cobalt therapy). No other medication tested was so successful.

—in fact, 63 per cent of these Roncovite treated patients delivered with the unusually satisfactory level of 13 Gm. per cent hemoglobin.

—Roncovite (iron-cobalt therapy) was proven to be the most effective hematinic. In fact, 57 of 58 patients (98.2%) maintained or improved their hemoglobin values.

RONCOVITE IS A SAFE DRUG.

in pregnancy—

"No toxic manifestations associated with its use have been observed."[1]

In prematures—

"None of them showed harmful effects despite the large doses..."[2]

In pharmacology—

"Histopathologic studies of rats that received cobaltous chloride ...revealed no significant degenerative changes in parenchymal organs as evidence of toxicity."[3]

SUPPLIED:

RONCOVITE TABLETS

Each enteric coated, red tablet contains:

Cobalt chloride..... 15 mg.
Ferrous sulfate exsiccated..... 0.2 Gm.

RONCOVITE-OB

Each enteric coated, red capsule-shaped tablet contains:

Cobalt chloride..... 15 mg.
Ferrous sulfate exsiccated..... 0.2 Gm.
Calcium lactate..... 0.9 Gm.
Vitamin D..... 250 units

RONCOVITE DROPS

Each 0.6 cc. (10 drops) provides:

Cobalt chloride (Cobalt 9.9 mg.)..... 40 mg.
Ferrous sulfate..... 75 mg.

DOSAGE:

One tablet after each meal and at bedtime. Children 1 year or over, 0.6 cc. (10 drops); infants less than 1 year, 0.3 cc. (5 drops) once daily diluted with water, milk, fruit or vegetable juice.

1. Holly, R. G.: Anemia in Pregnancy, Obstet. & Gynecol. *5:*562 (April) 1955.
2. Quilligan, J. J., Jr.: Texas State J. Med. *50:* 294 (May) 1954.
3. Hopps, H. C.; Stanley, A. J., and Shideler, A. M.: Polycythemia Induced by Cobalt, Amer. J. Clinical Path. *24:* (Dec.) 1954.

Bibliography of 192 references available on request.

RONCOVITE

The original, clinically proved cobalt-iron product

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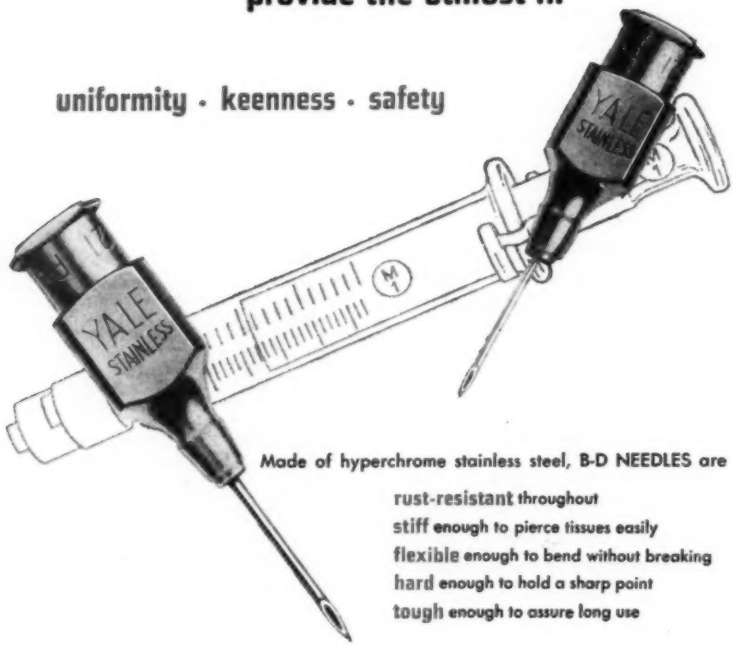
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by any standard...

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provide the utmost in

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Made of hyperchrome stainless steel, B-D NEEDLES are

rust-resistant throughout
stiff enough to pierce tissues easily
flexible enough to bend without breaking
hard enough to hold a sharp point
tough enough to assure long use

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of the earth: oil, gold, and other metals—and, of course, in uranium, the current favorite. But you can also find them in a wide list of other enterprises. Some recent penny offerings: race tracks, Geiger counters, sporting goods—even pizza pie.

3. *Which stock exchanges deal in penny stocks?*

Many such offerings are not listed on any exchange but are sold only over the counter. Where they are listed, it's usually on exchanges in the West—Salt Lake City, San Francisco, and Spokane, for instance—or in Canada. A handful of these stocks also appear on the American Stock Exchange.

4. *How do you buy penny stocks?*

When an offering first comes out, you can't buy it from anyone except the underwriter (i.e., the investment house that buys all the stock from the company and then sells it to individuals at so much a share). Later, when the stock is being traded, you can buy through your regular broker—although he'll probably try to discourage you. Often, too, the stock is sold by high-pressure salesmen, who are likely to phone you around dinnertime, to catch you at home.

Commissions Are High

The commission paid for a penny stock when it first comes out is included in the purchase price. The rate is set by the underwriter, and it generally amounts to 25 per cent. That is, the stock you buy for 15 cents a share is actually priced at 12 cents, with a 3-cent commission tacked on.

Once the stock is traded, the commission you pay conforms with regular New York Stock Exchange rates. These are so adjusted as to take account of the *number* of shares traded as well as of their *cost*. So the purchase and sale of a penny stock are bound to be relatively more costly than the purchase and sale of a more conventional stock.

Suppose, for example, you buy—and eventually sell—$500 worth of a 50-cent stock. The total commission on the 1,000-share transaction will come to a whopping $60 ($30 to buy, $30 to sell). On the other hand, you'd have to pay only a $20 commission ($10 to buy, $10 to sell) on ten shares of a $50 stock.

Hard to Keep Track

Assuming that your penny stock appreciates at all, it'll have to appreciate quite a bit to compensate for those stiff commission rates. And it isn't easy to keep track of the price changes, so as to sell at just the right moment to realize a profit.

The financial pages of the newspapers list only a few of the penny stocks. To learn bid-and-asked prices for most of them, you've got to keep in touch with your broker, who gets daily reports from the National Quotation Bureau.

What do *you* get? You get handsomely engraved stock certificates to attest to your ownership of the shares. And if there are any profits



Hemorrhoids needn't hurt

Hemorrhoids need not pain, itch or burn. Inflammation, congestion and pressure can be quickly reduced with Anusol Suppositories.

Prompt, lasting relief of pain and itching: Anusol relieves anorectal discomfort almost immediately upon insertion. Action is soothing and decongestive. Relief is prolonged.

Safely: Anusol contains no narcotic, analgesic or anesthetic drug. Thus the danger of masking more serious rectal pathology is eliminated.

Easily administered: Anusol is easy to insert. Comfort plus efficacy, especially where prolonged use is necessary, contribute to patient acceptance.

Safe in any situation: Because Anusol does not narcotize, the presence of strangulation, ulceration, malignancy or prostatic disease is not concealed. Diagnosis and treatment of co-existing disorders (anal fissures, infected crypts, polyps, warts, abrasions, abscesses, etc.) are not impeded. Anusol does not produce rectal anesthesia which aggravates concurrent constipation.

Dosage: One suppository, morning and night and after each bowel movement.

Packaging: Boxes of 6, 12, 24 individually foil wrapped suppositories.

Anusol®

Suppositories

WARNER-CHILCOTT

(and if the directors decide to distribute them), you get dividends.

5. *How is the price of a penny stock determined?*

Unlike other stocks, whose prices bear some relationship to actual value, penny stocks—at the outset, at least—often sell at a price that could be picked out of a hat. One underwriter in the field has explained his pricing technique this way:

"Our first issue came out ten years ago, at 60 cents a share. The next one was at 30 cents. Then we put an issue out at 15 cents. Each time we dropped the price, the stock sold better. Then we put an issue out at 5 cents a share. Sales were way off; people must have thought the stock was too cheap to be of any potential value. So we went back to 15 cents, and we've stayed there with all the issues since. Maybe 15 is my lucky number. At 15 cents, the cost of 1,000 shares is $150. That's what people like. A thousand shares at a time makes them feel solid; and $150 is a nice, easy figure."

6. *What makes penny stocks so highly speculative?*

As I've said, they're mostly in businesses that hope to exploit the riches of the earth, but that haven't yet done so. Since Nature is reluctant to give out advance information on what she has hidden in the ground, locating her buried treasure



"Oh, he's *much* better this morning, Doctor. He tried to kick me!"



14 different symptoms in 14 different patients pointed to a single diagnosis— ***depression***

Watts[1] saw varied, ill defined, and apparently unrelated symptoms—such as the ones below—in 14 of his patients:

insomnia—fainting—pain in chest—indigestion—fatigue—dizzy spells—cough—asocial behavior—fear of being alone—weeping bouts—loss of interest in job—irritability—chronic invalidism—heavy drinking

For each of these patients, he made the same diagnosis: depression.

Watts found—as countless other physicians have discovered—that when he specifically treated these patients for depression, their miscellaneous psychosomatic complaints vanished.

'Dexedrine' Sulfate *Spansule* capsules assist in restoring such patients to normalcy by providing day-long relief from depression, renewing interest and optimism and restoring the capacity for physical and mental effort.

Dexedrine* Sulfate

dextro-amphetamine sulfate, S.K.F.

Tablets • Elixir • Spansule* capsules (*brand of sustained release capsules*)

Smith, Kline & French Laboratories, Philadelphia

1. Brit. M. J. 1:11, 1947. *T.M. Reg. U.S. Pat. Off. Patent Applied For

is usually a highly expensive proposition, with no guarantee of a pot of gold at the end of the drilling. So companies engaged in such operations have little but hope to go on. What they're looking for from investors is strictly risk capital—with the accent on the "risk."

Not so most other companies that offer stock to the public. They are already in business. What *they're* looking for is money that will allow them to expand their operations.

There's an element of risk in all investments, of course. But in penny stocks it's generally the *dominant* element.

Slim Pickings?

7. *Do penny stocks sometimes pay off?*

G. Keith Funston, president of the New York Stock Exchange, has estimated that of 10,000 "penny-stock ventures touted by the high-pressure boys," not more than one usually turns out to be profitable. Mr. Funston is justifiably irritated by fraudulent stock-selling, because of the black eye it gives the securities business; so he can be forgiven a bit of exaggeration.

A good number of penny-stock issues *do* fall by the wayside. But not everyone who bought in necessarily loses his money. The trick, if you can do it, is to get in on an issue on the ground floor—when it's just coming out—and to get out fast.

The romantic appeal of uranium, for example, is such that a new issue may be grabbed up in a hurry. After that, the bloom wears off, the stock droops, and another group of shareholders joins the ranks of the disillusioned.

Timing's the thing: If you can manage to make a fast in-and-out killing on your first penny-stock venture, you then have profits on which to gamble. At least that's the theory.

They're Not Dishonest

8. *Doesn't the Securities and Exchange Commission have any control over penny stocks?*

Sure it does—if the company is an American one. But Canadian stocks are another thing. And even in the case of U.S. concerns, the S.E.C. can't do much more than forbid manipulation and insist on honest announcements. It makes no effort to tell you what to buy and what not to buy.

"These securities are a speculation," says a typical penny-stock prospectus in bold type on page 1. Then follows the familiar S.E.C. disclaimer: "The Commission does not pass upon the merits of any securities nor does it pass upon the accuracy or completeness of any offering circular or other selling literature."

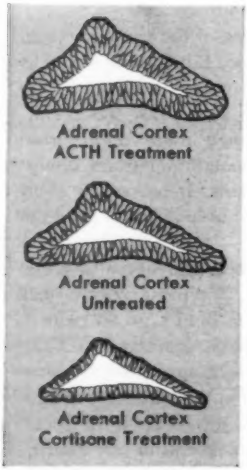
In plain English: Watch your step!

Here's an illuminating paragraph from this same prospectus (the italics, of course, are mine):

"*In the judgment of the Company,* the preliminary exploratory and geological work on the fore-

Q Should atrophy of the adrenal cortex as a result of corticosteroid therapy be prevented?

A ***Yes*—it should be prevented! Atrophy of the adrenal cortex with loss of secretion of adrenal cortical hormones deprives the patient under cortisone therapy of a defense mechanism which can assume vital importance when exposed to unexpected stress.**



THERE IS A DIFFERENCE BETWEEN ACTH AND CORTISONE

For this reason, the response of the adrenal cortex must be preserved. *It can be preserved* by utilizing the antagonism between ACTH and cortisone or hydrocortisone at the adrenal cortical level.

ACTH is capable of counteracting the negative influence of cortisone on the adrenal cortex by its opposite, positive effect on function and structure of the adrenal gland. ACTH *stimulates* . . . cortisone *depresses* adrenal cortical function.

The goal thus is:
To obtain all therapeutic benefits without sacrifice of the adrenal cortex by counterbalancing cortisone with ACTH.

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THE ARMOUR LABORATORIES
A DIVISION OF ARMOUR AND COMPANY · KANKAKEE, ILLINOIS

going uranium properties warrant carrying on of further exploratory work to test the areas. *The operations to date,* however, have been *too preliminary* in nature to indicate *the extent, if any,* that the Company may have ore on its properties, and *no implication* with respect thereto *is intended.* In addition, *insufficient information* is available at the present time in order to determine the quantity and value of ore which must be discovered before mining operations can be conducted on a commercial basis. Until further geological, exploratory and development work is done, *the Company will not be in a position* to ascertain whether its properties, or any of them, contain ore in commercial quantities."

Along with the prospectus, the underwriter sent out a letter to his customers. Its key sentence: "This is a new company—we do not know what they will find when they start their drilling and exploration program—but we like the possibilities because the property is located in an area where anything can happen."

There you are. Nothing unethical about *that,* is there?

Should You Invest?

Do penny stocks have a place, then, in the doctor-investor's portfolio?

Truth is, they may be just the thing for the practitioner whose income runs solidly into five figures, and who needs some harmless relaxation. Penny stocks can be fun, just as a turn at a roulette wheel can be fun, if you don't get taken.

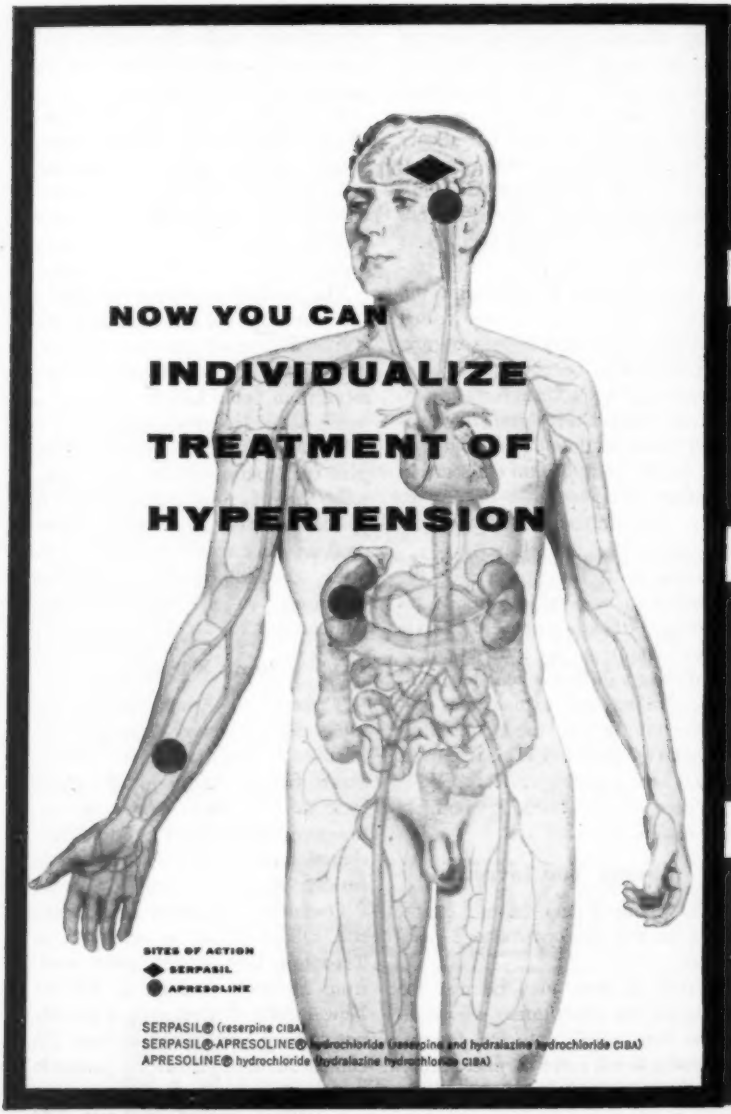
As a matter of fact, the thrill usually lasts considerably longer. Often it takes months before you realize you can't get rid of your Whatzis Uranium at any price. And even then you have some attractive stock certificates to show for your pains.

The correct approach to penny stocks is much the same as it is to the horses. You won't put your life savings into Whatzis Uranium any more than you'd bet the price of a much-needed X-ray machine on a lively filly in the fifth. If you want to play with penny stocks, you'll consider them as fun, nothing else. If you lose a bit of money—well, you've paid for your entertainment. If you make the killing the promoters promised you over the telephone, you can chalk it up to good luck.

Some Winners

Through the years, admittedly, some penny stocks have brought fortunes. The fabulous Charles Steen, Gilbert LaBine, and Vernon Pick are the best known of the uranium millionaires; and they have shared their wealth with a host of small investors.

Quemont, a postwar stock that's still talked about in whispers in Toronto's Bay Street, once went from 18 cents a share to $29.50. New Larder U took only a month, not so long ago, to travel from 12½ cents a share to $2.65. [MORE ▶


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Serpasil-Apresoline	Tablets, each containing 0.1 mg. of Serpasil and 25 mg. of Apresoline Tablets, each containing 0.2 mg. of Serpasil and 50 mg. of Apresoline
Apresoline	Tablets, 10 mg., 25 mg., 50 mg. and 100 mg. Ampuls, 1 cc., 20 mg. per cc.

CIBA
SUMMIT, N. J.

During last summer's boom on the Salt Lake City Exchange, when more than 7 million uranium shares were traded in a single day, a stock named Timco bounced up 6,900 per cent; and some others weren't far behind. (Timco, incidentally, is an honest-to-goodness penny stock: It came out originally at one cent a share.)

But don't let such tales excite you—unless you get excited every time you hear about the file clerk who just won $75,000 on the Sweepstakes. Your chances for the one kind of windfall are about as slim as they are for the other.

If you still insist on taking fliers in penny stocks, you may be interested in a few suggestions. When asked for pointers on buying uranium stocks, a nationally known figure who had moved from atomic energy into investments drew up the following list:

1. Be sure the company is a going one.
2. Check the property titles to the claims.
3. Make sure that an engineering report has been made and that the presence of commercial-grade ore has been proved.
4. Take such a report to an engineering consultant for evaluation.
5. See how many shares are being offered, to check how diluted the profits would be. If 10 million





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Dosage: On retiring, ½ to 1 tablespoonful taken in milk, water, juice or miscible food. Repeat if needed the following morning two hours after eating. Contraindications: symptoms of appendicitis; idiosyncrasy to phenolphthalein.

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shares are outstanding, simple arithmetic tells you that the company in question would have to net $5 million a year—a tall order—in order to give a profit of half a dollar a share.

6. Consider investing only in established companies in the field, those with staying power and know-how. Some of the big-name companies currently in uranium are Atlas Corp., Anaconda and Kennecott Copper, National Lead, Vanadium Corp., Climax Molybdenum, and Union Carbide and Carbon.

Obviously, these six points add up to good advice. But, just as obviously, they'd be practical only for the man who's about to do some *serious* investing. For the doctor who'd enjoy earmarking a few hundred dollars for a flier, the job of tracking down all that information would cost more than the stock in question was worth.

So it boils down to this: The level-headed investor who wants to play games with penny stocks doesn't let himself take them seriously. He gambles with limited stakes; and he doesn't waste much time trying to find ways to beat the nonexistent "system."

Where your serious investments are concerned, you naturally want expert help—whether from a broker or an investment counselor—in developing a balanced portfolio. The penny stocks can remain a side issue, representing not more than 1 per cent of your total holdings. They're strictly for laughs. END

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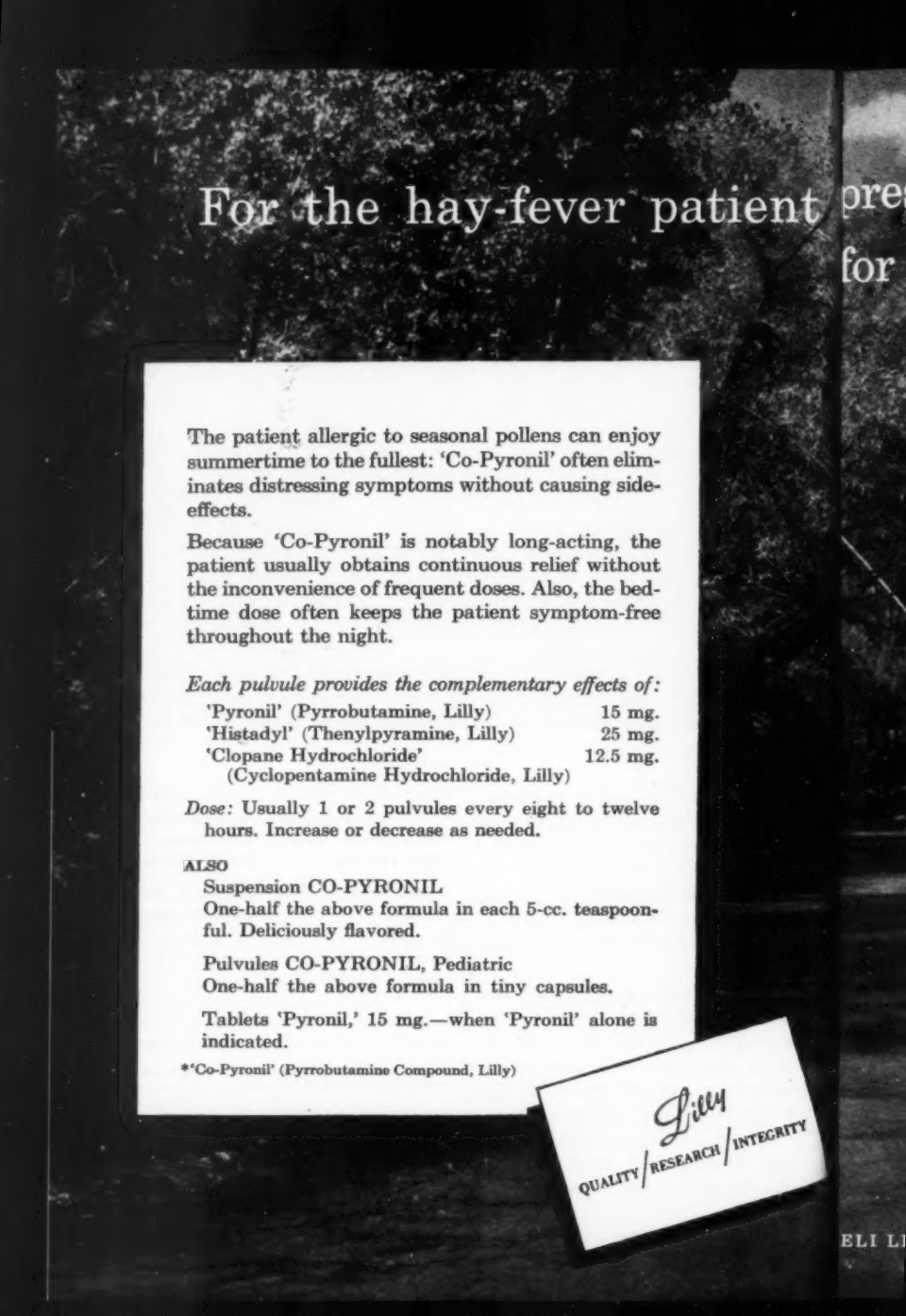
Medical Economics, Inc. Oradell, N.J.

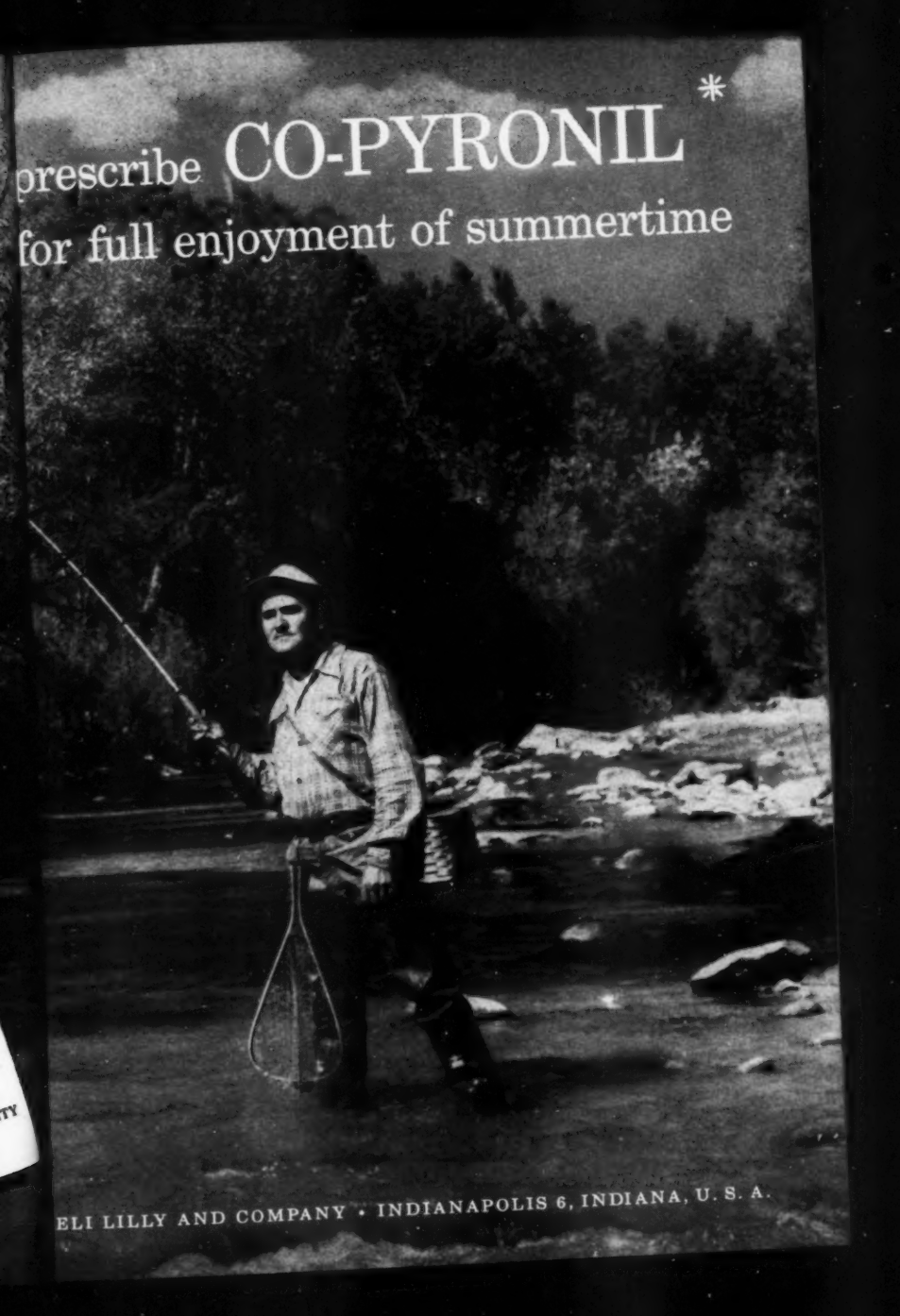
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Dose: Usually 1 or 2 pulvules every eight to twelve hours. Increase or decrease as needed.
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One-half the above formula in each 5-cc. teaspoonful. Deliciously flavored.
Pulvules CO-PYRONIL, Pediatric
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How to Make Bequests

A badly-drawn will may be worse than none at all. Here's a quick review of things you should—and should not—do when drawing yours

By Arnold G. Malkan, LL.B.

● "I give, devise, and bequeath $15,000 to the Brixton Clinic, and all the rest, residue, and remainder of my estate to my wife . . . "

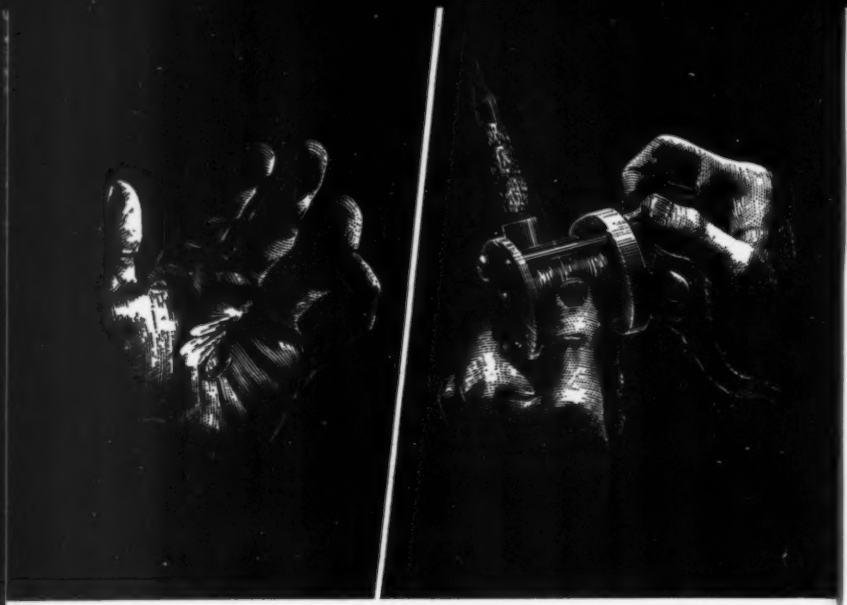
That's from the will of a physician who died leaving about $100,000 in securities. He had wanted 85 per cent of his money to go to his wife. But before his estate could be settled, the bottom dropped out of his principal investments. The clinic got its $15,000; which meant that, after investment losses, taxes, and legal costs, his widow got less than $12,000.

Any competent lawyer writing the will could have prevented this miscarriage of the doctor's wishes. The proper wording would have left the clinic "fifteen per centum of my residuary estate, not to exceed $15,000." Despite the heavy investment loss suffered by the estate, the doctor's widow would then have received $23,000, the clinic only $4,000.

To have a lawyer draw up your will may cost $25 or more, depending on the size of your estate and its complexities. But the cost is usually well worth while.

If you die intestate*, as nine out of ten do, the probate court will allow your wife only one-third of your

*Without a will; not, as one law student defined it, "demise following a double testectomy."



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When the rigidity and pain of arthritis and related rheumatoid disorders prevent the patient from enjoying a normal, satisfying life, Acetycol may open a road to rehabilitation. Therapy with Acetycol provides welcome relief of pain and increases the range of pain-free movement. Thus the patient is able to resume more normal activities in his work and relaxation.

The effectiveness of Acetycol is based on synergism between aspirin and para-aminobenzoic acid. The combination of these two agents produces high salicylate blood levels on relatively low dosages. Salicylated colchicine extends the effectiveness to cases of a gouty nature.

Acetycol also contains three essential vitamins often lacking in older patients: ascorbic acid, to prevent degenerative changes in connective tissue; thiamine and niacin, for carbohydrate utilization and relief of joint pain and edema.

Usual dosage—1 or 2 tablets three or four times a day.

Each Acetycol tablet contains:

Aspirin	325.0 mg.
Para-aminobenzoic acid	162.0 mg.
Colchicine, salicylated	0.25 mg.
Ascorbic acid	20.0 mg.
Thiamine hydrochloride	5.0 mg.
Niacin	15.0 mg.

Supplied: Bottles of 100 and 500.

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WARNER-CHILCOTT

estate. The rest will go to your children. And the kids, as minors, can't turn it over to their mother even if they want to. If you have no children, your widow may still be out of luck. Your blood relatives may then be awarded the lion's share.

Let Them Watch

However you draw up your will, do it with an eye to the few simple rules that will help make it valid. Most important rule is probably this: See that the document is signed, dated, and properly witnessed. More wills are thrown out of court for imperfect witnessing than for any reason.

Some states require two witnesses, some three. Play safe and have four; a spare or two may come in handy. Pick people younger than yourself—settled members of the community who are not likely to move away. Don't pick a beneficiary as witness; it would probably disqualify him from receiving the bequest you had in mind. And don't pick anyone who might conceivably benefit by seeing your will upset.

Make It Foolproof

Get your witnesses together and tell them this is your last will and testament. This is legally termed "publishing" your will. Sign it in their presence. Then have them sign it with each of them actually looking on (judges can be fussy about the formalities of witnessing). Be sure to have each witness add his address.

If your will meets these technical requirements, and if it makes your wishes absolutely clear, it will probably stand. Most judges want to be sure only that it is your will, and that you were of "sound and disposing mind" when you made it.

A will in your own handwriting (a "holographic will") is often the strongest kind. Some states don't even require that it be witnessed. Courts have been known to uphold wills written on walls, on prescription blanks, on pillowcases, even on a stepladder. One will was held legally sound though it contained only the single word, "Mother."

Be Explicit

It's a good idea, however, to be a bit more explicit. To begin with, name an executor to settle your debts and to execute the provisions of your will. If you're leaving all to your wife, you may wish to appoint her executrix, thus saving the estate an executor's fee. Or, if you feel the job may be too much for her, you can designate your bank or lawyer as a co-executor. While you're about it, name an alternate executor, to fill in if a primary executor dies.

Of all your belongings, perhaps the easiest to dispose of are personal effects. Yet many people don't even mention them. With a little forethought, you can spare your heirs the sentimental pangs of seeing that

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In a controlled study, Crunden and Davis[1] clearly established the value of EMETROL in nausea and vomiting of pregnancy. EMETROL produced favorable responses in 78.8 per cent of 123 patients, as compared with only 14.8 per cent of 122 patients receiving a placebo of like appearance and taste. Relief was usually secured within the first 24 hours of treatment. EMETROL was found to be a *safe, physiologic* agent, free of annoying side actions. Containing no drugs likely to induce untoward effects, EMETROL is easy and pleasant to take, safe for all age groups.[2,3]

DOSAGE: 1 to 2 tablespoonfuls on arising, repeated every three hours or whenever nausea threatens.

IMPORTANT: EMETROL must always be taken *undiluted.* Fluids should not be allowed for at least 15 minutes after each dose.

SUPPLIED: In bottles of 3 fl.oz. and 16 fl.oz. through all pharmacies.

In epidemic vomiting (acute infectious gastroenteritis, intestinal "flu"), EMETROL works rapidly, even in refractory cases; control is usually established with the first few doses, "often with a single dose."[2]

1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311, 1953. 2. Bradley, J. E., et al.: J. Pediat. 38:41, 1951. 3. Tebrock, H. E., and Fisher, M. M.: M. Times 82:271, 1954.

Literature and sample on request

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treasured portrait of Uncle Egbert go under the auctioneer's hammer for 50 cents.

Inheritance taxes are a big factor in shaping an estate of any size. Your home state will take a cut; but Federal taxes are the main levy on sums of $60,000 and up.

One way you can minimize taxes is to give away some of your property during your lifetime to people who are going to inherit it anyhow. You have a lifetime tax exemption on such gifts to a total of $30,000. Besides, you can give, tax free, up to $3,000 each to any number of individuals in any one year. (But note that the Government takes a dim view of gifts made by anyone in anticipation of his demise.)

Another tax-saving device is the trust fund. If you're leaving enough so that your wife can live on the income, a trust will avoid taxation of the estate all over again when she dies. You can pass it on in trust and tax free (after initial taxation) as far as your grandchildren.

In providing for your youngsters, it's best to leave equal shares and not to mention the children by name. This will take care of any offspring born after your will is drawn.

While you're remembering loved ones, you may want to add a note about others whose possible enjoy-



"Maternity Hospital. And never mind rushing . . . I only work there."

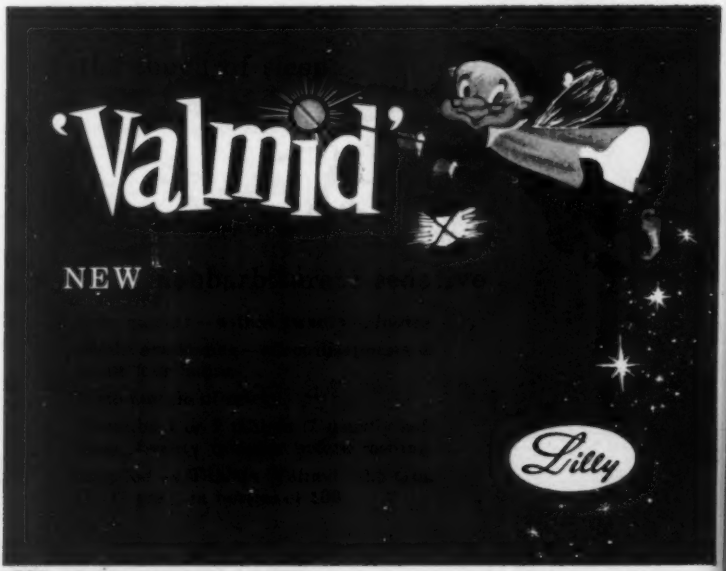
ment of your hard-earned funds might set you to revolving under ground. The way to cut off that no-good nephew is by name and in so many words: "To So-and-So I leave nothing." Then he can't tell the judge you really doted on him but somehow overlooked him.

A wife is the only person a man can't cut off in his will. The banker who wrote, "To my wife I leave her lover and the knowledge that I wasn't the fool she thought I was," didn't get away with it. Under the law, a wife is entitled to at least one-third of her husband's estate, whether he mentions her or not.

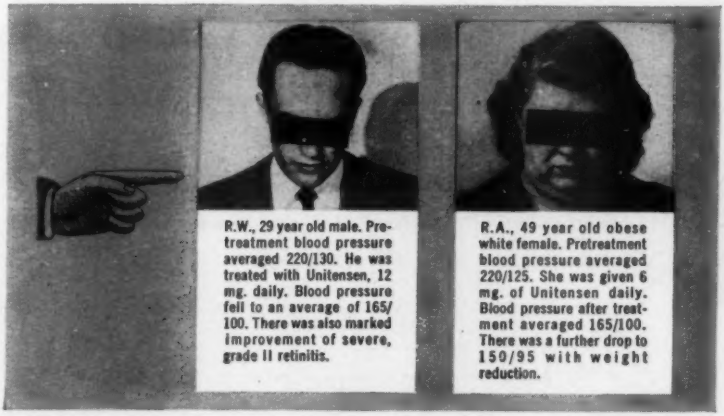
It's important to check over your will from time to time. If you find that changes are in order, burn it and write a new one. Or you can append a codicil. This, like the original document, must be dated, signed, and witnessed.

Finally, have your wife make a will at the same time you make yours. This is especially important if you've put much property in her name. Recently, in New York State, an elderly, well-to-do man transferred all his security holdings to his considerably younger wife. Unexpectedly, she died first, leaving no will. A good portion of the property went to her niece. The shocked widower was able to claim only a little more than half of his wife's estate.

END



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How Britons Get Cheap Malpractice Insurance

Here's a firsthand report on the nonprofit, doctor-staffed 'medical defense' societies that seem to work so well over there

By Edwin N. Perrin

● The American doctor now pays anywhere from $17 to $226 for malpractice insurance coverage with $5,000/$15,000 limits. His British colleague pays an annual premium of about $6 for *unlimited* protection.

How is this possible? Well, for one thing, British patients bring proportionally fewer malpractice suits than Americans do. And the same amount of money will buy more of *any* commodity—insurance included—in Great Britain than it will in the United States.

But part of the answer may also lie in the fact that British physicians *write their own* malpractice insurance through any one of three doctor-owned medical defense societies.

This system, its proponents say, cuts costs in at least three ways:

1. The doctor-owned societies are nonprofit.

2. There's a central pool of experience in defending malpractice suits that no one commercial company is likely to have.

3. The M.D.-cooperatives make a policy of *always* fighting nuisance suits—"to the House of Lords, if

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*Ingels, A. H.: California Med. 79:437, 1953.

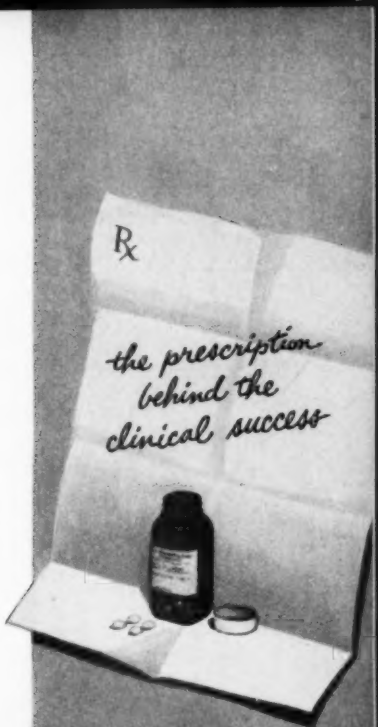
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necessary." Patients (and their lawyers) have learned this; so they're chary of bringing such suits.

In addition, there's said to be a fourth advantage: a close working relationship between the medical man and his defense society.

When the U.S. physician wants malpractice coverage, he buys it from any of several insurance companies, no two of which handle claims in exactly the same way. Some companies may fight even a weak case, as a matter of policy; so it's not unusual for an indefensible suit to wind up in court. Other companies settle perfectly defensible suits out of court. In either case, the American M.D. foots the bill, in the form of high premiums.

Why It Costs Less

The British doctor, on the other hand, takes *his* malpractice problem to the physician-secretary of his defense society. The secretary's sole job is to protect the interests of his fellow members, in and out of court. He has had wide experience in malpractice work; and as a doctor himself, he naturally sees matters from the medical point of view.

The British physician threatened with litigation generally tells his story fully and frankly, knowing that he's got a sympathetic ear. And the secretary, who has probably handled many similar cases, is able to make a shrewd guess about how things will go in court, and to act accordingly. Result: few wasted shillings.

To sum up, the British defense societies offer the premium-cutting advantages of being nonprofit, widely experienced in the field, unafraid of nuisance suits, and on good working terms with their members. Could a similar set-up bring equivalent advantages to American doctors?

Several physicians here in England have told me they believe it could. They realize that such a plan would have to be tailored to the American scheme of things. But they think some form of U.S. medical defense society *could* be made to work. And here's how they visualize it:

A Plan for Us

Because of widely varying state laws in the U.S., they would organize the society into independent state or regional units. Each unit would set its own rates and collect its own premiums. A single, large-state unit would be organized at the start as a pilot plan.

The defense society would be operated independently of the A.M.A. Why? Because any medical association must be partly a disciplinary body; and you can't expect the same men who may have to sit in judgment on you to act as your defense counsel, too. The three big cooperatives in the United Kingdom work hand-in-hand with the British Medical Association, but are in no way controlled by it.

Each state defense society would be run by an elected council of practicing physicians. This council could

meet once or twice a month with the full-time M.D.-secretary and the society's lawyers, to decide policy and consider new cases.

An Honor to Serve

In Great Britain, election to such councils has come to be a distinct honor. Among the men now functioning there in that capacity are at least one peer of England (a practicing M.D.) and several of Harley Street's most distinguished practitioners.

To raise the initial funds needed, the first members of each U.S. defense society would be asked to make a non-interest-bearing loan to it. The loan would be repaid in, say, five years, after the society was on its feet.

Until a sufficient reserve fund accumulated, premium rates might have to be nearly as high as those of the commercial companies. But after that, if all went well, a cut in premiums would naturally be possible.

How would such a society avoid having its reserve fund drained off by an unusually heavy settlement? The British doctors recommend reinsurance with a commercial company. Even after sixty-odd years in business, their cooperatives are strongly reinsured with Lloyd's; and they consider this "extra reserve" as the real backbone of their safety.

Many Hurdles

Obviously, many obstacles would have to be overcome before a malpractice self-insurance society could be established for U.S. doctors. Not the least of those obstacles would be inertia. But the prospect of lower premiums is a powerful incentive.

The British system may not be the right system for America's physicians. Even so, it's worth thinking about because it suggests at least a last-resort method of coming to grips with a growing problem. END

Two and Two

● I was summoned to examine a patient with pernicious vomiting of pregnancy. Since other medication had proved of little value, I told the ward nurse—a recently licensed practical—to bring me a hypodermic with one cc. of vitamin B_6.

Ten minutes later, the girl fidgeted into the room.

"Doctor," she confessed, "we have no vitamin B_6 . . . How about half a cc. of B_{12}?"—EDWARD D. MORTON, M.D.

Ins and Outs of the Tax on House-Sale Profits

Under certain circumstances, you can escape the capital gains tax. Here's a round-up of things to consider before closing that profitable deal

By John C. Post

● A doctor-neighbor of mine recently brought me a problem that he expressed in this way:

"I'm about to sell my house, and I've been offered an excellent price—far more than I paid for it originally. Now I've read somewhere that if you go out and buy another house, you don't have to pay a capital gains tax on the profit you make on the first one.

"But," he added, "I also seem to recall hearing that you have to buy the new house within a certain time, and that you have to spend a certain amount for it. So just to make sure I don't outsmart myself—and end up with an unexpected tax bill—I'd like to know exactly what the rules are on those points."

I told the doctor he had the basic idea right; all he needed was some filling in on details. So I briefed him in a few minutes. The briefing (in case you, too, would like to brush up on the finer points) went along these lines:

First, I explained the general Federal law on the taxation of profit from house sales. The law says that if such

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MR. POST *is a tax and management consultant in Washington, D.C.*

a profit is to be free of capital gains tax, you must meet two requirements:

1. Within one year before or after the date of sale, you must buy *and occupy* another house; and

2. You must pay at least as much for it as you got for the old one.

It was soon clear that my doctor-neighbor intended to fulfill both conditions: He'd paid $10,000 for his present home ten years ago. Now he was being offered $15,000 for it. Since he planned to invest the entire $15,000 in another place right away, he wouldn't have to pay a tax on the $5,000 profit.

I pointed out to him that if the new house were to cost only $14,000, he'd have to pay a long-term capital gains tax on the $1,000 of profit he hadn't reinvested. And then, since he hadn't yet either sold the old place or bought a new one, I discussed some of the other possibilities.

Let's suppose, for example, that the doctor decided to buy a dilapidated old house for $10,000 and to spend at least $5,000 on remodeling it. What then? He'd have no capital gains tax to pay in that case, either. For, in the eyes of the law, the cost of reconstruction is part of the cost of buying.

Or suppose he decided to *build* a new house with the $15,000 he got for the old place. The basic rule

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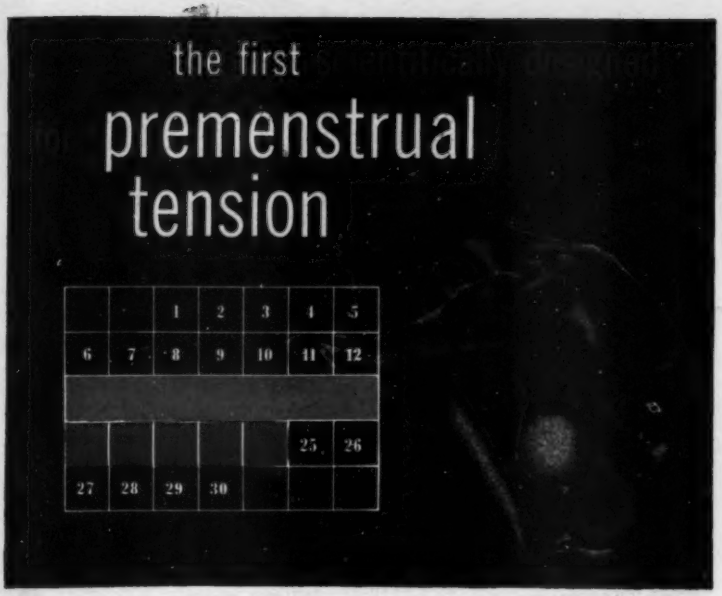
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Dosage: 2 tablets twice daily (morning & night) beginning at onset of symptoms —usually 5 to 7 days before menses. Discontinue at onset of flow. Supplied in bottles of 100 tablets on prescription only.

1. Bickers, W.: Southern M.J., 46:873, Sept., 1953
2. Greenblatt, R.: GP, 11:66, March, 1955

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1. Finnerty, F. A., Jr.: The Value of Rauwolfia Serpentina in the Hypertensive Patient, Am. J. Med. 17:629 (Nov.) 1954.
2. Moyer, J. H., in discussion of Galen, W. P., and Duke, J. E.: Outpatient Treatment of Hypertension with Hexamethonium and Hydralazine, South. M. J. 47:858 (Sept.) 1954.
3. Livesay, W. R.; Moyer, J. H., and Miller, S. I.: Treatment of Hypertension with Rauwolfia Serpentina Alone and Combined with Other Drugs; Results in Eighty-Four Cases, J.A.M.A. 155:1027 (July 17) 1954.

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would still be the same: To avoid taxes on the profit, he'd have to pay out at least as much for building the new house as he got from the sale of the old one.

When you build (rather than buy) a home, you get a further concession: Though you must *start* construction within one year of the sale, you needn't *occupy* the house until eighteen months after the sale date. So even if the doctor didn't turn the first sod until a year after he got rid of his old house, he'd still have six months' grace in which to get a roof over his head.

A Special Case

In general, it's fairly easy to apply the law. But there's one special case that requires a bit more arithmetic: the sale of a combination home-office. Why? Because the no-tax-on-profit rule applies only to personal residences. If you sell a building that you've used partly for professional purposes, you can't avoid paying a capital gains tax on the share of the profit allocable to the office portion.

For instance, say you get $30,000 for a home-office that cost you $15,000 ten years ago. Assume that you use two-thirds of the house for your residence and one-third for your office. Here's how to determine the Federal tax on your $15,000 profit:

One-third of the sales price ($10,000) obviously represents what you're getting for the office portion of the house; and you'll have to pay a capital gains tax on as much of that $10,000 as the Government considers profit. So all you have to do is a little simple arithmetic:

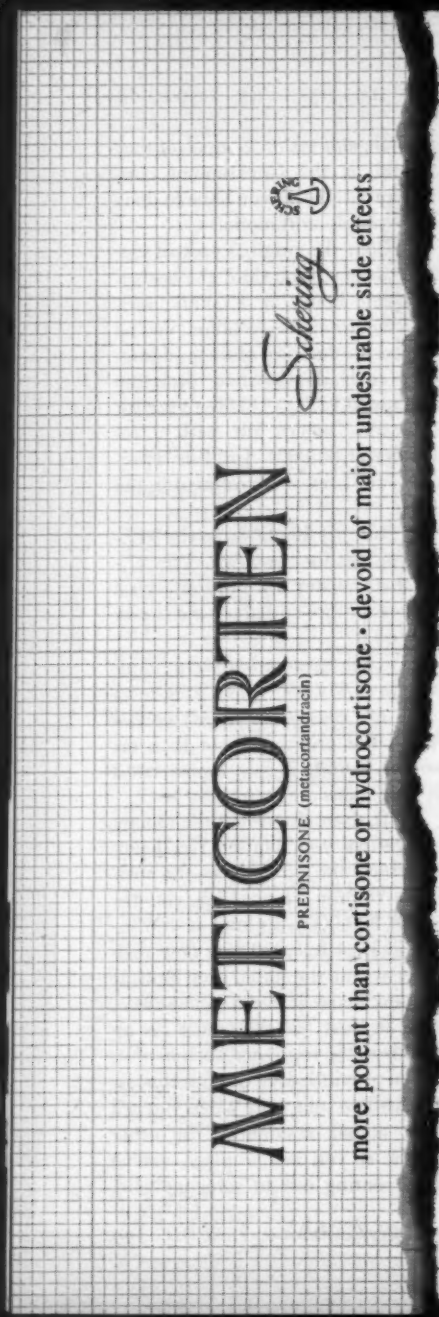
1. From the original cost of the office portion (one-third the cost of the whole house, or $5,000), subtract the total depreciation you've claimed for that part of the building. Since such depreciation probably amounts to $2,000 ($200 a year for 10 years), you're left with a remainder of $3,000. And this represents your present investment in the office.

2. Subtract $3,000 from the $10,000 you get for the office. The $7,000 that remains is your profit. It's a business profit—and *you have to pay taxes on it.*

So you'll report a long-term capital gain of $7,000. (It's a long-term gain, of course, because you've owned the property more than six months.) And, as you know, taxes on such gains are mercifully low.

What about the rest of the money you get for your house? You'll pay no tax on the profit from the residence portion (for which you received $20,000), as long as you invest at least $20,000 in a new residence within the stated time limit. If the new house is also a home-office, then at least $20,000 must be allocable to the residence portion of it.

You're entitled to the tax concession, as I've said, only when you sell your actual *residence.* In other words, if you sell a place you've been renting out to someone else,



the profit on such a sale is considered a business gain—and thus fully taxable.

One exception: If, after buying a new house, you rent out the old one only until you can find a buyer, the rented house is still considered your residence for tax purposes. (But you'd better be prepared to prove your good faith in such a transaction.)

Here are answers to a couple of other questions you may be asking:

1. What if you own two homes? Answer: You're permitted the no-tax-on-profit privilege only when you sell your *principal* residence.

2. What if you sell the stock you own as a tenant-stockholder in a cooperative apartment building? Answer: You're entitled to the same treatment as if you'd just sold a private home.

Finally, just to prove that no possibility has been overlooked, the Internal Revenue Code adds that you're entitled to the special tax treatment when you sell "a houseboat or a house trailer" if it really has been your principal residence. (There's nothing in the law, though, about tents.)

Gifts and Exchanges

So far we've talked only of property transfers in which you *sell* your house and *buy* (or build) another residence. But in some transactions there may *be* no real "selling" or "buying"; and the law covers those transfers, too. For example:



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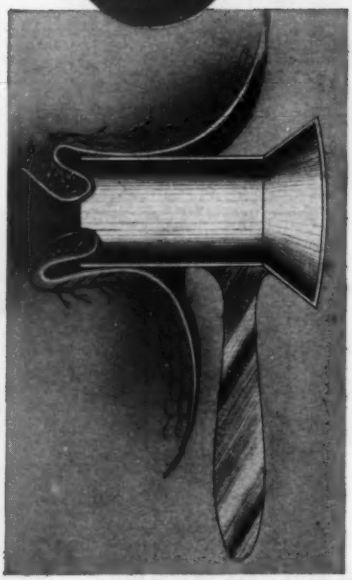
Seamless Stick-Dots and Stick-Patches are packaged for easy, convenient use, as above. Stickbands come in handy wall or desk dispensers.

Pliable, plastic backing and firm adhesive mass are quality features of these outstanding bandages by Seamless. They contain *fatty acid salts, zinc propionate* and *zinc caprylate* which minimize itching and irritation. The nearest approach to skin in a bandage, they won't slide or skid. Packaged 100 to a box. Please order through your Surgical Supply Dealer.

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¶ Suppose your father-in-law leaves you a house in his will; and you move in and sell your old house at, say, a $5,000 profit. The law: If you don't spend at least $5,000 for capital improvements on the new house within one year, you'll have to pay a tax on your profit.

¶ Suppose you swap houses with someone else. If no money changes hands, you're not considered to have earned a taxable profit, even though the house you get may be worth more than the one you traded. But if you got the other house plus, say, $1,000 in cash, you'll have to invest at least that much in improvements in order to avoid taxes.

¶ Suppose the state decides to put a highway through your property and buys your house for more than you paid for it. Even in such forced sales, you have to reinvest the amount you were paid if you want to avoid being taxed on the profit. But in such cases you're allowed more time to find a replacement: The profit won't be taxed if you buy and move into a new home within one year after *the close of the taxable year* in which the state paid you the money.

It's the Net Price

These, then, comprise most types of situations you might meet in making a profit out of selling your house. If you apply the law to a real case, though, remember this:

Throughout this article, I've used round figures for the sake of simplicity. In an actual property transfer, however, you'll want to make your tax calculations on the basis of the *net* sales price of the old house and the *total* purchase price of the new one.

These figures are easily arrived at: To get the net sales price, subtract from the actual sales price (1) the broker's fees and selling expenses and (2) any money spent for improvements (such as painting and redecorating) aimed at making the house easier to dispose of. (But remember that you can deduct such refurbishing expenses only if the work was performed within the ninety days preceeding the date of sale—and was paid for within thirty days after the sale date.)

Conversely, to find the total purchase price of the new house, add to the actual price paid any broker's fees and other legal expenses incurred in the purchase.

Only Once, Please

Here are two final pointers:

1. The no-tax-on-profit rule applies to only one sale or exchange in a given year. So you can't engage in a profitable multiple transfer within twelve months without paying taxes.

2. If you're called to serve in the armed forces, the time limits for buying or building your new house are extended. Check with your local Internal Revenue Service office to find out exactly how much time you'll be allowed. END

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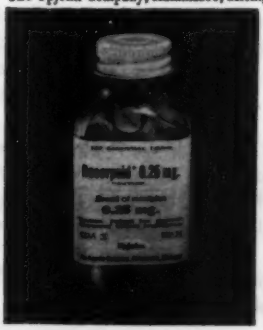
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Car Makers Veto Doctors' Safety Devices

Auto manufacturers say none of the devices recommended by organized medicine is feasible

By Charles Hammond

● Last year, the nation's doctors suggested the installation of a number of safety features in new-model cars. Was their collective voice heard? The answer, as shown by a recent survey of manufacturers: No.

At last June's A.M.A. convention and at the November meeting of the American College of Surgeons, members of the profession discussed in some detail the value of various auto safety devices. Out of their discussion came these proposed safeguards against injury:

¶ Seat belts, to keep passengers in a crash from "rattling around like teacups shipped loose in a barrel."

¶ Front seats solidly anchored to the car frame.

¶ Four-inch thick foam-rubber padding on the dashboards.

¶ Better locks for doors (as in planes), to keep them from flying open.

¶ Steering rods that would telescope under the impact of a body.

¶ Front ends specifically designed to absorb the shock of high-velocity impact.

¶ Reinforced roofs.

But you'll probably get no such features with your next car. For in conversations with MEDICAL ECONOMICS,



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ANTISEPTIC LIQUID SOAP

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the automobile manufacturers say they're unconvinced of the safety value of the suggested items—or of their feasibility from an engineering view. Take the question of seat belts, for example:

Seat Belts

Ford and Chrysler both feel that they lack proper criteria for judging the safety value of such belts. Ford reports that its safety engineers are testing such devices at the present time. A Chrysler spokesman says, "It has not yet been conclusively proved that the passengers in a crash *should* always be restrained from leaving their seats." (Chrysler is willing, however, to install an airliner-type seat belt for anyone who really wants one.)

Nash-Hudson points out that it tried the belts in its 1949 models but that it soon discontinued them. "The public considered them a 'nuisance,'" it explains. "Perhaps what's



To doctors with high expenses and low income . . .

Why run the risk of too little protection?

No one needs tell the young doctor how pressing his needs for protection are. His growing family, his mortgaged home and his unpaid obligations incurred in training are constant reminders.

Yet, when he needs protection most—and when the lower rates for younger men make it most advantageous to buy—the young doctor, faced with the expense of establishing a practice, is least able to afford this protection.

What can he do? Does he have to postpone coverage till income rises and risk family security in the meanwhile? Does he have to skimp along on make-shift protection? *No. There is a way . . .*

MANAGED DOLLARS . . . a new security concept, developed by Mutual Benefit Life for physicians exclusively, takes into account the young doctor's unique situation. Managed Dollars gives the young doctor and his family the full permanent protection they need now . . . at a cost they can *afford now.*

Under this unique plan—costs are fitted to the doctor's earning pattern, not present income. Lower at first . . . increasing as income rises.

And this is done without sacrifice of benefits. In fact, Managed Dollars starts immediately to lay the foundation for successful retirement . . . compensates for the doctor's lack of Social Security benefits and company sponsored retirement plans. And, if he qualifies, it assures the doctor of disability benefits that have been called by a leading medical publication, "the most liberal offered."

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Let your Mutual Benefit Life man arrange a mutually convenient appointment to tell you more about Managed Dollars. You can call him directly or have your nurse drop us a note on your stationery.

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needed is a re-education of the American motorist."

Other companies are apparently just not ready to make such innovations. Says Studebaker-Packard, cryptically: "There is no simple reason why we are not installing these devices."

Other Replies

Kaiser-Willys, disregarding the seat-belt query, lists instead the "safety features" of its present models (e. g., "the new 'Super Hurricane' engine with 27 per cent more horsepower").

Most of the manufacturers answered MEDICAL ECONOMICS' questions briefly and in broad terms. But one of the auto makers, General Motors, stated its objections to the doctors' proposals in some detail. Here's part of the G.M. reply (given by an official of the company's Vehicle Safety Section):

On seat belts: "It is my opinion, based on considerable investigation . . . that few persons—except those interested for specific reasons in the sale of seat belts—would go to the trouble of fastening them after the novelty wore off."

New Front Seats

On anchored front seats: Installing such seats "would mean the elimination of the fore-and-aft adjustment feature . . . and the verti-

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cal-adjustment feature, which is becoming increasingly popular."

On telescoping steering rods: "There are serious complications from the standpoint of design, manufacture, and service life . . . And even though the column telescoped the maximum number of inches, the steering wheel . . . could induce abdominal injuries of a much more serious nature than the average chest injuries [now sustained]."

Need Both Hands

On airplane-type door locks (with slide bolts that fasten all parts of the door): "These would necessitate door handles . . . at least eight to ten inches long to overcome the friction of the bolts; and some persons [would have] to use both hands to unlatch doors of cars long in service . . . The idea is absolutely impractical, because of the mechanism required."

Padded Dashboards

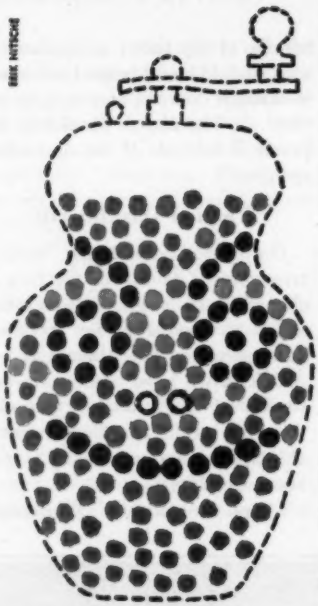
On padded dashboards: "Such an arrangement would require four inches of inside length . . . and would make it impossible for front-seat passengers to cross their legs . . . Although we have made numerous studies of the available materials, there is a serious question of acceptable appearance—especially as a car becomes older."

Were the doctors' suggestions,

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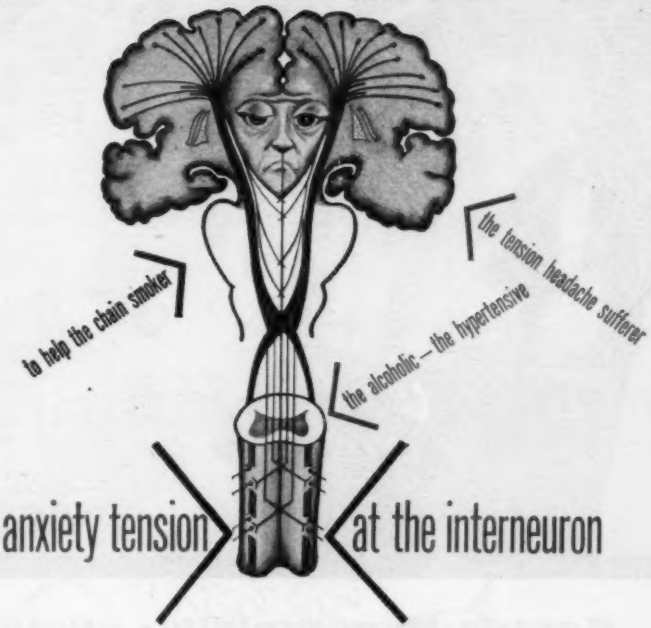
WHITEHALL PHARMACAL COMPANY • NEW YORK, N. Y.

then, unrealistic? Many safety engineers would deny it—among them, the directors of the Government-financed Crash Injury Project at Cornell University Medical School. They don't recommend all the precise safety specifications urged by the medical men; but they say their research on the causes of auto injuries has proved that such injuries could be drastically reduced by means of seat belts and fairly simple changes in car design.

Survey Findings

A six-state survey of accident cases, made by the Cornell project, shows that nearly 18 per cent of the injuries in those cases resulted from people being thrown out of cars. (Proposed safeguards: seat belts





DIMETHYLANE safely blocks *abnormal* impulses at the interneuron to relieve tension and relax spasm. It has little effect on normal impulses, and none on the higher centers. DIMETHYLANE is the *safe* tension relaxant, tranquilizing the patient:

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DIMETHYLANE stops anxiety tension safely, without even partial or temporary weakening of voluntary motor functions. It is more effective than mephenesin and has a wider margin of safety. In fact, there have been no reports of toxicity to DIMETHYLANE.

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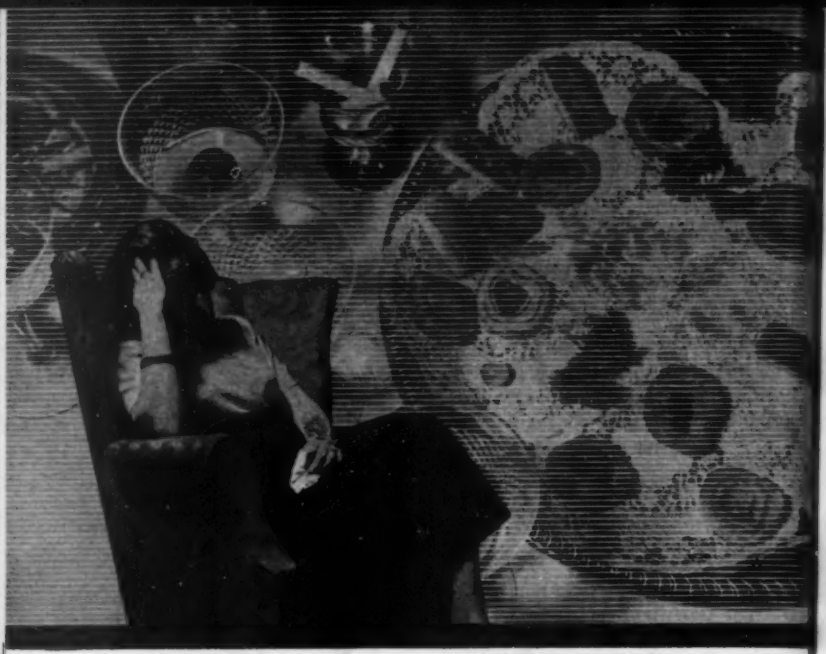
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Free from constipation: Gelusil's aluminum hydroxide component is specially prepared: the concentration of aluminum ions is accordingly low; hence the formation of astringent—and constipating—aluminum chloride is minimal.

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and more securely fastened doors.) For victims within the car, major dangers were found to be unpadded instrument panels (13 per cent); windshield frame and glass (11 per cent); rigid steering column (11 per cent); other projecting components, such as door handles and window cranks, (10 per cent).

Could such major hazards be materially lessened if the automobile companies made the effort? They could, indeed, say the Cornell men, adding that auto safety could be increased especially by applying the results of research into shock-absorption.

In this connection, John O. Moore, director of the Cornell project, says: "At present, we can drop an egg from the top of a twenty-three story building onto a special energy-absorbing pad—and not even crack the shell!"

That's a thought-provoking statement. For if eggs can be made crash-proof, one M.D. asks, "how much longer will car owners be content to remain potential Humpty Dumptys?"

END



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Tips on Reading Wisely

What's the secret of getting the most out of the time you spend with books and papers? This M.D. advises selectivity, system, and seclusion

By Charles Miller, M.D.

● In his reading, as in his eating, a professional man needs a system and a set of well-formed habits.

It's true that of the making of books and journals there is no end. I know colleagues who subscribe to as many as twelve scientific journals; but I know none who read that many in an orderly fashion.

Data are showered upon us, as Will Durant once put it, like ashes from Vesuvius. That only means we must be more selective in our reading. There is no time for any but the best works by the best authors. To use my reading time intelligently, I follow these eight rules:

1. *Learn to skim off the cream.* I scan the final summary paragraphs of a journal article first, then decide whether I want to read the whole text. I skip paragraphs that explain points already clear—as well as other paragraphs that never will be clear.

2. *Stop reading when a book or article loses interest for you.* Occasionally, you find a work in which the author says his say in the first two or three chapters and the rest is just sawdust. Just because I paid $5 for a book, I don't feel called on to spend $20 worth of time looking for something that isn't in it.

I could get no dividend out of Herbert Spencer's "First Principles," for instance, beyond Part I. But that was

enough to make it, in my view, one of the world's great books. Similarly, not many will wish to pore over every sentence in Dr. Harvey Cushing's fine "Life of Sir William Osler." It's a river of words, which should be seined for the big fish, letting the minnows go.

To keep my interest from flagging, I've found it a good rule to read mostly the newer medical books and the older general books.

3. *Set up a time budget.* It should be divided into three parts. My own budget for my most active years was fifteen hours a week—five hours each for medical literature, general periodicals (including newspapers), and general books.

4. *Read with a purpose.* Every man's interests tend to form a mental channel; the object of his reading is to deepen and broaden that channel. Reference reading is intensive boning up on one topic; development reading expands the mind and supplements the experience. But some reading is a positive vice.

The habit of devouring great chunks of matter in which one is not particularly interested reminds me of an amateur collector I once knew. He accumulated stamps, books, cut glass, anything and everything. "Some day this stuff may be worth a lot of money," he told me.

It never was. Because he bought less from a genuine connoisseur's

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interest than from the fear he might overlook something, he merely filled his attic with junk.

Just as mentally debilitating is the habit of picking up a piece of reading matter every time you have two minutes between appointments. I agree with grumpy old Schopenhauer that this is the surest means of driving away any thoughts of one's own. A novelist once told me he wouldn't read even a newspaper early in the morning; for his mind then had been emptied and refreshed and he was ready to start the most creative part of his day.

I've found that when I was wrestling with a difficult diagnosis, my faculties were blunted by reading more than necessary to dig up some specific fact. At such times, reading is only second-hand thinking.

5. *Don't give yourself entirely into an author's hands.* Stop and recall experiences that confirm or contradict the words of the author. Read, as Bacon counseled, "not to contradict and confute, nor to believe and take for granted, but to weigh and consider."

I try to follow Mortimer Adler's advice: Locate the basic propositions in a book, then write them down on a flyleaf or in a notebook. My method is to have a red pencil at hand and underscore or bracket significant passages. Sometimes I write brief comments in the margin. If the

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book or periodical is not my own, I use a loose-leaf notebook.

6. *Devise a simple system for nailing down the important facts in your reading.* I mark journal articles that I expect to refer to, and have them clipped. My secretary indexes the clippings on 3 x 5 cards for filing. (It's not usually necessary to index articles in the journals I keep permanently, since most professional periodicals publish cumulative indexes.)

7. *Don't worry because you fail to remember everything you read.* It's as impossible to retain every printed word as it is to retain all the food you ingest. Even what you've forgotten has nourished your mind and become a part of your thinking.

8. *Have a special place where you can read and study without interruption.* Every doctor, it seems to me, needs one room in his house where he can enjoy solitude in the company only of his books.

Nothing in this world is so personalized and individual a possession as a man's library. When you stock it regularly and just as regularly weed out material that no longer justifies space, your library becomes an intimate part of your intellectual life. It's a place to go for either counsel or consolation.

For years, now, I've been able to read myself out of most of my worries. END

CORTEN

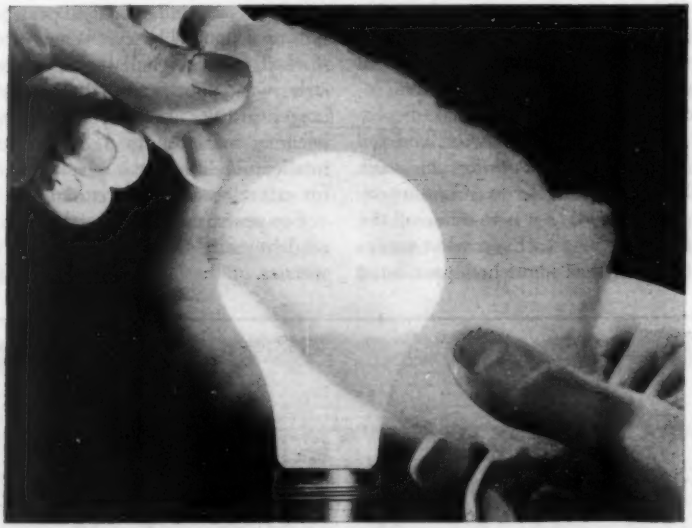
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Music Hath Charms

But after plowing through a scholarly book on its therapeutic uses, this writer says his savage breast feels anything but soothed

By Justin Dorgelch, M.D.

● Someone has just dumped into my lap a book that could easily revolutionize the practice of medicine. "Music Therapy"* is the title, and the text clearly indicates that sonatas, cantatas, and lullabies will some day be ensconced in the U.S. Pharmacopoeia. The physician who wouldn't know C-sharp from B-flat had better hop on the band wagon: Music is destined to replace phenobarbital, ulcer diets, and perhaps even vagotomy and splanchnic resection.

"Music Therapy" is a collection of essays by various writers including doctors, musicians, music therapists, psychologists, clinical psychologists, a dentist, and a Director of Logopedics. What they talk about can best be gathered from a look at a few of the book's chapter headings:

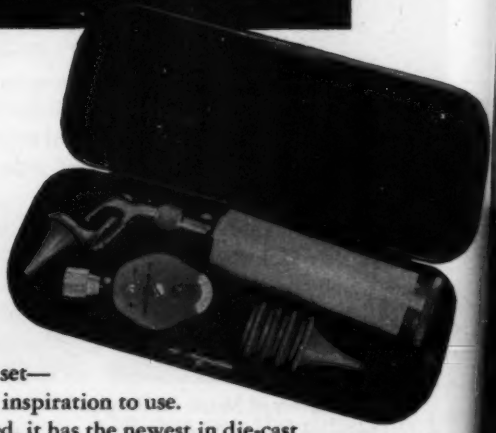
"Effects of Music on Respiration—and Heart-Rate" . . . "The Relation of Music to Diseases of the Brain" . . . "Music Therapy in the Anxiety States" . . . "A Musical Program for Emotional High Blood Pressure" . . . "Music Therapy in Psychosomatic Gastric Disorders" . . . "The Organism-as-a-Whole and Music Therapy" . . . "The Effects of Personal Insecurity on Reactions to Unfamiliar Music."

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*Edited by Edward Podolsky, M.D. Philosophical Library, New York, 1954. $6.



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SINCE B&L 1853

I* am actually not too well qualified to pass judgment on the merits of Music Therapy, for pages 21 to 52 seem not to have been included in my copy and there's no telling what gaps there are in my grasp of the subject.

Unsolicited Comments

But *somebody* has to bring Music to the attention of those doctors who may still practice a sort of musicless medicine. And perhaps the indulgent reader will allow me a few unsolicited comments.

Now, I realize that even the run-of-the-mill doctor has long been aware of music as a regulator of mood (for example, the synergistic effect of etchings and soft music is proverbial). But does he appreciate the full potentialities of musical pharmacology?

Lest the uninitiated think that musical drugs are not as specific as, say, insulin or digitalis, I hasten to submit fragments of but three of the prescriptions to be found in "Music Therapy":

Three Prescriptions

1. For high blood pressure:

Bach: "Concerto in D Minor for Violin" . . . Beethoven: "Sonata No. 8 in C Minor" . . . Brahms: "Quartet No. 1 in G Minor" . . . Debussy: "Pour le Piano" . . . Tschaikowsky:

*(A pathologist).

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"Swan Lake Ballet" . . . Rachmaninoff: "Isle of the Dead."

(Author's note: I have friends whose blood pressure *rises* at the sound of a violin. And "Isle of the Dead" might not always be reassuring either.)

Gastric Music

2. For psychosomatic gastric disorders:

Bartok: "Sonata for Violin" . . . Schumann: "Sonata in A Minor, Op. 105" . . . Satie: "Three Pieces in the Shape of a Pear."

(Author's note: I have friends in whom the violin *induces* indigestion. And be sure to check pear tolerance before administering Satie's composition.)

3. For jealousy and suspicion*:

Bach: "Cantata No. 21" . . . Beethoven: "Fantasia in C Minor" . . . Scarlatti: "Cat's Fugue" . . . Debussy: "La Mer."

(Author's note: *Not* recommended: "Frankie and Johnnie"; "I Wonder Who's Kissing Her Now.")

Real Gone Science

The basic-scientists of musicology are not content with mere empiric prescriptions, however. "Music Therapy" delves into the very molecules and prosthetic groups of musical chemistry.

Here are some fundamental data that prove to me, at least, that one's psyche is a helpless Trilby to a set of tuning forks:

Emotional Quality	*Relative Frequency*
Sadness	.45
Joy	.41
Rest	.39
Love	.35
Longing	.30
Stirring	.28
Dignity	.20
Reverence	.14
Amusement	.12
Irritation	.08
Disgust	.02

The above list is on page 108 of "Music Therapy." On page 260 another writer reports:

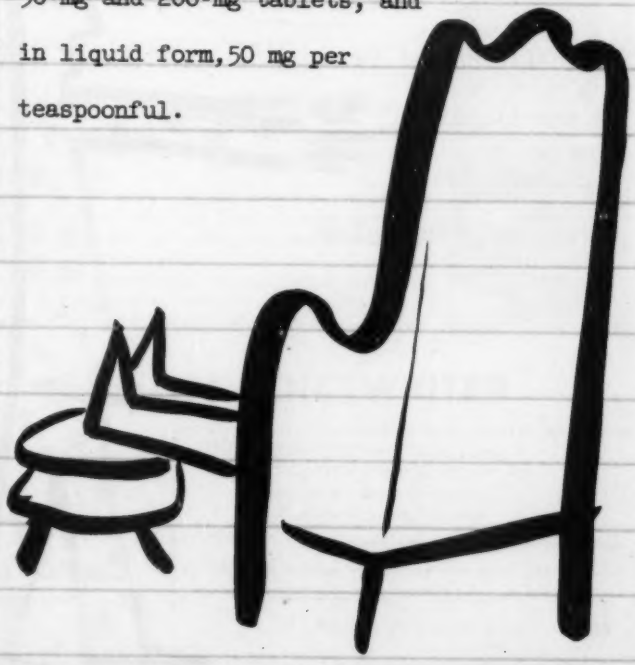
"High pitch calls forth happy, bright feeling and low pitch characterized by gloomy or melancholy in Western minds. The reverse is true in Orientals."

The alert reader, noting that sadness and joy are veritable vibrational siblings, at the very top of the frequency range on page 108, can only conclude that those experiments were carried out on individuals who were half Western and half Oriental.

But there is more to musical medicine than just pitch. "Music Therapy" makes that clear in discussing a clinical case of athetotic tremor of the right index finger:

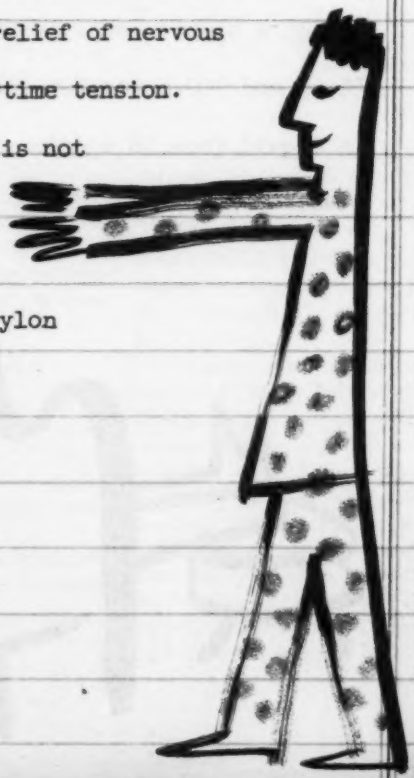
*"Music Therapy" points out: "Jealousy arises when A loves B and A identifies B as loving C."

at ease... you may put your own mind at ease as well as calm your patient when you prescribe Noludar as a sedative (or in larger dosage as a hypnotic). There is little danger of habituation or other side effects because Noludar is not a barbiturate. Available in 50-mg and 200-mg tablets, and in liquid form, 50 mg per teaspoonful.



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		Vitamin K (Menadione)	2 mg.

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PEARL RIVER, NEW YORK

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*REG. U. S. PAT. OFF.

"From the complete analysis it would seem that pizzicato chords or single notes in harmonic progression, and in beat with the tremor, would have been more effective than spiccato a ricochet . . . However, use of the pizzicato alone might have produced the same results."*

So much for a thumbnail sketch of "Music Therapy" as a book. Now, I don't want to implicate the authors in anything I have to say about the subject. Let's leave them to their work; and let's consider shaping music to everyday office practice.

Any physician can, with a little practice, compose his own therapeutic melodies. For maximum potency, he must remember to fit the vibrational frequency to the ailment (taking into account, of course, whether the patient is Western or Oriental). The resulting purity of pitch will be akin to purity of drug, antibiotic, or estrogenic hormone.

(One must remember that men like Mozart and Beethoven produced crude hodgepodges of tones suited only for the ear, with no regard whatever for the hypothalamus or vagus nerve. Their multiple sonata-form themes can cause a patient's mood to quiver like an aspen leaf.)

For the physician who is timid about composing his own therapeu-

*The patient's tremor reportedly disappeared only when the music *stopped*. This appears at first glance to be a paradox, which I suppose it is.



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tic music (he may fear that any opus-in-monotone of his might induce nothing more than boredom or irritation in the patient) there is always creative plagiarism. Why not, say, a Bach theme here, a Schumann cadenza there, all chosen for therapeutic effect and joined together on one long-playing record? The local record shop could fill such a prescription while the patient waited.

Of course, we'd eventually have competition from the patent-music firms. For example, some television commercial might come up with:

"Do you suffer from psychosomatic gastric disorders? Then try our special long-playing record. Not from one or two composers, but from *dozens* of scientifically compounded masters. Like a doctor's prescription!"

A word of warning to the physician is in order, though: That list of emotion-vibrations on page 108 of "Music Therapy" leaves no doubt that a full-range symphony or even a simple nocturne might well have unpleasant *side effects*. Furthermore, if music can benefit sufferers from hypertension and gastric disorders, the wrong music can probably *cause* hypertension or gastric disorders (in a patient being treated for jealousy, for example).

The prudent physician will see to his malpractice insurance before embarking on music therapy; and he will certainly shut off the unfiltered music that now inundates his reception room. END

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MILTON, WISCONSIN

Don't Take Chances With Your Property Title

Without a title search and title insurance, you may find yourself in a legal battle for land you thought surely you owned

By Ralph Coniston

● Some years ago, a Midwestern G.P. bought a lot in a pleasant section of the town where he practiced. He then proceeded to build his dream house. Everything was fine until recently; then the bolt struck: He found out he didn't really own the place.

The doctor had bought his lot from a man who lacked a valid title to it. The seller hadn't deliberately hoodwinked him; he was as surprised as the doctor when the title proved faulty. Neither knew that one of the previous deeds to the property had been forged.

The forgery went unnoticed until the son of the man whose signature had been falsified came to town to check on his holdings. As soon as he saw the house on his land, he figured he had the doctor over a barrel. And he did. He made the physician pay twice the actual value of the land in return for a valid title.

The physician tried to collect from the man who had sold him the lot. But the seller had since gone bankrupt and couldn't make good. Even if he could have, he would have been liable for only the original sum paid, since the sale had been made in good faith. [MORE ▶

It's hard to believe that forged deeds are one of the biggest headaches of title abstracters and title insurance companies—to say nothing of the buyers.

Yet it's a fact.

Impossible to Detect

"Forged signatures on deeds," says John A. Albert, of the Inter-County Title Guaranty and Mortgage Company of New York, "are practically impossible to detect during a title search. They come to light, as a rule, only when the legal owner turns up with an eviction notice."

Forged deeds are, of course, only one of many title hazards that may await the real estate buyer. The validity of your title can be challenged for any of a number of reasons.

Take, for example, what happened to an Eastern specialist: He arranged to buy a city lot from an agent who had power of attorney from the legal owner. But the day before the sale went through, the owner withdrew such power from the agent.

No one bothered to tip off the doctor—who was rudely awakened when he found he'd paid for land the seller had no right to dispose of.

Or witness what happened to a California practitioner who bought a house and lot: He didn't know it at the time, but the second owner

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before him had died and the property had been sold to settle the estate. One "prodigal" son of the deceased owner hadn't been represented in the sale.

The deceased's other children assumed that the missing heir had no rights. But since the father had died without leaving a will, the son still had a legal claim to part of the estate. As a result, it cost the medical man plenty in time, trouble, and legal fees before he was able to win a settlement.

Slip-Ups Occur, Too

Even when title to a property is clear, the boundaries may be open to dispute. Many old deeds are worded

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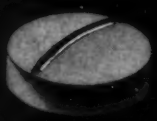
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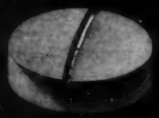
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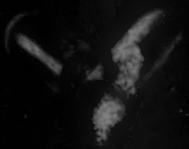
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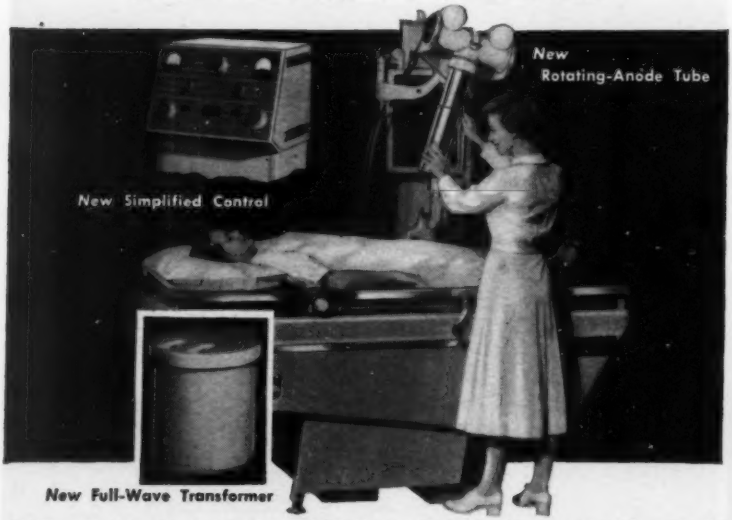
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so indefinitely as to give title to something like this: "the land running from the tree with the split fork due north as far as a man can ride a horse while he smokes a pipeful of tobacco." There are also surveyors' errors and just plain slip-ups to reckon with—and they're far from rare.

An Indiana physician, for instance, was trying to sell his house when he found out that it extended approximately five feet into a neighbor's land.

Luckily for him, the neighbor sold the necessary ground at a reasonable figure. Otherwise, the doctor might have found himself in a bad spot.

Rights-of-Way

Easements (i.e., rights-of-way across land for roads, power lines, pipe lines, and the like) are another big cause of trouble. Such rights-of-way may be established by written agreement or by practice. Those created by contract can be uncov-



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Each cc. contains: Physostigmine salicylate, 0.6 mg. and l-hyoscyamine hydrobromide, 0.3 mg.

SUPPLIED 1-cc. ampuls, boxes of 25; 10- and 30-cc. multiple dose vials. See package circular for dosage.

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H-U inject-oral therapy

then... for
sustained comfort
PRESCRIBE
SALIMEPH-C tablets
TRADEMARK



Each tablet contains: Salicylamide, 250 mg.; mephenesin, 250 mg., and ascorbic acid, 15 mg.

DOSAGE 2 or 3 tablets q.i.d.

SUPPLIED Bottles of 100, 500, and 1000 tablets.

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Laboratories in Milwaukee

ered only by a careful search of legal records. Those stemming from practice are likely to be physically evident—hence, easier to detect.

But no matter how an easement originates, it is a legal right. If it runs through your property, it can't be lightly set aside.

Take the case of a Missouri physician who bought a lot in the country, intending to put up an expensive new home.

He paid little attention to a trail that snaked across his land. But when he started to build, he was served with an injunction barring erection of his house.

Here's what had happened: A former owner had let a neighbor drive over the land to save a two-mile trip to the main road. This practice, continued over a number of years, had established an easement. And the neighbor refused to give up his legal right-of-way on any terms.

Further Catches

A flock of other jokers may also keep you from getting maximum use out of your property. For example:

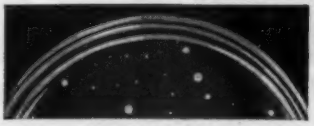
¶ A Baltimore physician obtained an apparently clear title—but from a man who hadn't been free to sell. Reason: His divorced wife still had a claim to the property.

¶ A New Yorker owned a house on the strength of a title established



DIAL SOAP with Hexachlorophene effects 95% reduction in skin bacteria

Photomicrographs show why



With ordinary soap. Even after thorough washing, thousands of active bacteria remain on the skin.



With Dial soap. Daily use of Dial with Hexachlorophene eliminates up to 95% of resident skin bacteria.

1. *Reduces chance of infection* following skin abrasions and scratches because Dial effectively reduces skin bacteria count.

2. *Stops perspiratory odor* by preventing bacterial decomposition of perspiration, known to be the chief cause of odor.

3. *Protects infants' skin,* helps prevent impetigo, diaper and heat rash, raw buttocks; stops nursery odor of diapers, rubber pants.

4. *Helps skin disorders* by destroying bacteria that often spread and aggravate pimples, surface blemishes.

You know, of course, the remarkable antiseptic qualities of Hexachlorophene soaps, as documented in recent literature. Dial was the first toilet soap to offer Hexachlorophene content to the public. You can safely recommend Dial. Under normal conditions it is non-toxic, non-irritating, non-sensitizing. Furthermore, Dial Soap is economical, and widely available to patients everywhere.



From the laboratories of Armour and Company

Free to Doctors!

As the leading producer of such soaps, we offer you a "Summary of Literature on Hexachlorophene Soaps in the Surgical Scrub." Send for your free copy today.

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NOW

a new Robins' Extentab for

"all-day" or "all-night"

SEDATIVE THERAPY



on single tablet dosage

Phenobarbital—the sedative par excellence—is now available in the unique Robins' Extentabs dosage form, as 'Stental Extentabs'.

Each Stental Extentab contains ¼ gr. phenobarbital, one-third of which is released promptly on ingestion, and the balance gradually and evenly, to provide smooth, sustained sedation over a period of 10 to 12 hours... thus avoiding repeated dosage during the day, or awakening at night for additional medication.

Robins

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(Phenobarbital Extended Action Tablets)

EXTENTABS

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Ethical Pharmaceuticals of Merit since 1878

by a sixty-year-old court order. A few years ago, the state Court of Appeals ruled that the original court order was unconstitutional and that the title was therefore invalidated.

¶ An Ohio medical man found himself in a court battle to uphold the validity of a stranger's will. The



"Come on, Doctor! You're a regular feller. One little drink won't hurt you!"



"Dr. Othbutt? . . . Oh, yeah, nice guy. But drinks quite a bit, don't you think?"

heirs of a former owner were attacking the doctor's title to his home. "Don't worry," the defense lawyer told him. "Their case won't stand up in court." He was right. But it cost the physician $2,500 to prove it.

The Way Out

How can you steer clear of title blunders? Here are three pointers:

1. *Don't buy property without first having a title search made.* Make sure you hire a skilled abstracter to do it, too; and have his work verified by an examiner trained in real property law. A good examiner will check the title from its original grant (which may have come from the British, French, or Spanish crown) through each subsequent owner down to the present.

2. *Make sure your examiner has solid financial backing.* He's liable for errors in his work; but his liability will do you no good unless he has money to satisfy it.

3. *Take out title insurance (now available almost everywhere).* For a single premium—usually a fraction of 1 per cent of the property's value or a flat fee per $1,000 of liability—a title insurance company will guarantee the title's validity. If the title is later attacked, the company will defend it in court. If unsuccessful in its defense, the company will then reimburse you (up to the face amount of the policy) for your loss.

END

both patient and physician
may rest easier when...
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provides uneventful
daytime SEDATION
nighttime SLEEP
free of
residual symptoms of the barbiturates
gastric irritation produced by other chloral derivatives
dosage: *Sedative-Antispasmodic:* 0.25 Gm., 2 to 4 times daily. *Nausea or Motion Sickness:* 0.25 Gm., repeated in 30 minutes if necessary. *Hypnosis:* 0.5-1.0 Gm., ½ to 1 hour before retiring.
supplied: Gelatin capsules, 0.25 Gm. (3¾ Gr.) and 0.5 Gm. (7½ Gr.); bottles of 100.
Wampole

Report on Polio Vaccine Fees

[CONTINUED FROM 143]

trol the distribution of polio vaccine supplies."

But as MEDICAL ECONOMICS went to press last month, there was still plenty of resistance in Washington toward controls, especially high up in the Administration.

Mrs. Oveta Culp Hobby, Secretary of Health, Education, and Welfare, seemed determined to keep her department aloof from vaccine-handling. And President Eisenhower lent the full weight of his office to voluntary methods. He did say, though, that nothing would prevent the nation's youngsters from getting their shots, even if the Government had to purchase the entire supply of vaccine.

And what of doctors in the field? Where did they stand on this question of controls?

MEDICAL ECONOMICS' correspondents talked to many doctors in all parts of the country. In keeping with their professional tradition, most of these M.D.s saw no cause for Federal intervention. One Michigan G.P.—jab-weary after giving shots to 200 first- and second-grade school children in one day—made a typical statement:



rtran

Side effects, tolerance and cumulation are rare with CLORTRAN, Wampole's stable capsules of chlorobutanol. Chlorobutanol is among the safetest of all sedative-hypnotics, and is superior to chloral hydrate in that it does not upset the stomach. In fact, its carminative and anesthetic effect on the gastric mucosa has also established it as an antinauseant—in motion sickness, pregnancy, etc. The opinion of Dr. Beckman* is significant: "I think the profession would do well to use this drug (chlorobutanol) more often in insomnia."

*Beckman, H. *Treatment in General Practice* (Saunders) 1948

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Sedative — Hypnotic — Antinauseant

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Theron
(STUART)

Tablets:	Liquid:
30's and 100's	4 oz. bottles
Dose:	Dose:
1 tablet daily	1 teaspoonful daily

QUICK-ACTING, LONG-LASTING

CO-NIB
SOOTHES THE DISTRESS OF
TEETHING PAINS



MOTHERS WILL APPRECIATE YOUR PRESCRIPTION OF CO-NIB WHEN BABIES REACH THE TEETHING AGE.
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Main Street
SPARTA, N. J.
Samples and literature gladly sent on request.

"Let's be calm about this," he said. "The National Foundation program is moving well. Doctors everywhere are prepared to handle their private patients as the vaccine comes through. Production and distribution *do* seem to be slower than we'd hoped; but I'm sure that we'll have all the vaccine we need before the season is over."

Dr. Martin's View

Dr. Walter B. Martin, outgoing President of the A.M.A., conceded that there was some need for rationing; but he said that this could be handled "by ordinary mechanisms already available at the state and local level." He emphasized that "national control is not necessary."

Some physicians were less certain about this than Dr. Martin.

"I don't think national control is necessary," said Dr. Vincent P. Butler, president of the New Jersey medical society. But he went on to say that "we in the medical profession are in the middle. It seems to me that it would have been better to work out distribution details *before* the results of the tests were made known. As it is, we are now confronted with a situation . . . in which everybody is in the air over the shortage."

Dr. Charles Sandler, president of the Bronx County (N.Y.) society, went further. "I don't see that anybody could have any objection to such a [national] law . . .

"As far as the doctors are con-

Bulk makes the "Regularity" Diet work!

Rough or gentle, bulk comes from the cellulose of foods plus a liberal fluid intake. Where roughage is needed, your patient may eat foods raw or cooked. In the bland diet, his fruits can be stewed and vegetables puréed.

These are for bulk—

Fruits and vegetables are high in cellulose. And some like oranges, apples, beets, and carrots also provide pectin which absorbs even more fluid to form especially smooth, soothing bulk.

Whole grains not only contain cellulose, but provide vitamin B complex as well.

And lots of liquid to make the cellulose bulky—about 8 to 10 glasses a day. But not all of it has to be water.

Team them up for appetite appeal—

Boiled beets take on new interest when served in a sauce of orange juice combined with sugar, cornstarch, and butter.

Diced apples and dates pair nicely in a salad. Or for dessert, stuff cored apples with dates and bake in orange juice.

Currants, raisins, or cranberries make a tasty surprise in oatmeal muffins.

When your patient learns that these bulk-producing foods can be made appetizing, he's likely to make them a part of his regular diet and so prevent recurrence of his condition.



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Beer—America's Beverage of Moderation

An 8 oz. glass of beer supplies about 1/8 of the minimum daily requirement of Niacin as well as smaller amounts of other B complex vitamins.*

If you'd like reprints of 12 different diets, please write United States Brewers Foundation, 535 Fifth Ave., New York 17, N. Y.

*Average of American beers

cerned, it would solve the problem very nicely and make sure that there would be equitable distribution of the vaccine."

Shots for Adults

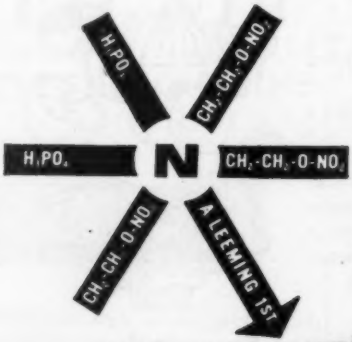
If Dr. Sandler shuddered less than most doctors did at the thought of Federal intervention, perhaps he had reason. His society was on the spot. The beginning of May had brought to light the fact that nine physicians in New York City—some of them members of Sandler's society—had flouted voluntary priorities and had administered the vaccine to seventeen adults. Since the children-first priority system lacked the force of law, it appeared that few of the medical men involved would suffer much more than a reprimand.

New York City doctors weren't the only ones who vaccinated adults. A cross-country spot check turned up the news that Milwaukee doctors had vaccinated twenty-eight adults; that about a dozen foreign-service officers had received shots in Washington, D.C., before going abroad; and that a few adults had been given the vaccine in Massachusetts.

How many *unreported* shots had been given to persons with no priority was anybody's guess. But it was plain that a little vaccine had fallen into a lot of hands. More headline-making disclosures seemed inevitable.

[MORE ▶

Angina pectoris prevention



Most efficient of the new long-acting nitrates, METAMINE prevents angina attacks or greatly reduces their number and severity. Tolerance and methemoglobinemia have not been observed with METAMINE, nor have the common nitrate side effects such as headache or gastric irritation. Dose: 1 or 2 tablets after each meal and at bedtime. Also: METAMINE (2 mg.) with BUTABARBITAL (¼ gr.), bottles of 50. THOS. LEEMING & CO., INC., 155 EAST 44TH STREET, NEW YORK 17, N.Y.

unique amino nitrate

Metamine

triethanolamine trinitrate biphosphate, Leeming, tablets 2 mg. Bottles of 50 and 500

New TENSOR adjusts itself to the swelling

maintains proper support—
without constriction—throughout
every stage of swelling

When swelling goes up . . . Tensor elastic bandage goes with it. When swelling goes down . . . Tensor goes down, too.

Tensor is made with Live Rubber Threads which provide *lasting* elasticity. It retains its positive stretch and snap back long after ordinary bandages are limp and lifeless.

Because of this, Tensor elastic bandage is able to give and take with the swelling. Never constricts. Never binds.

And with Tensor, doctor, you can bandage for low pressures as easily as higher pressures. Tensor elastic bandage holds whatever pressure *you* apply.

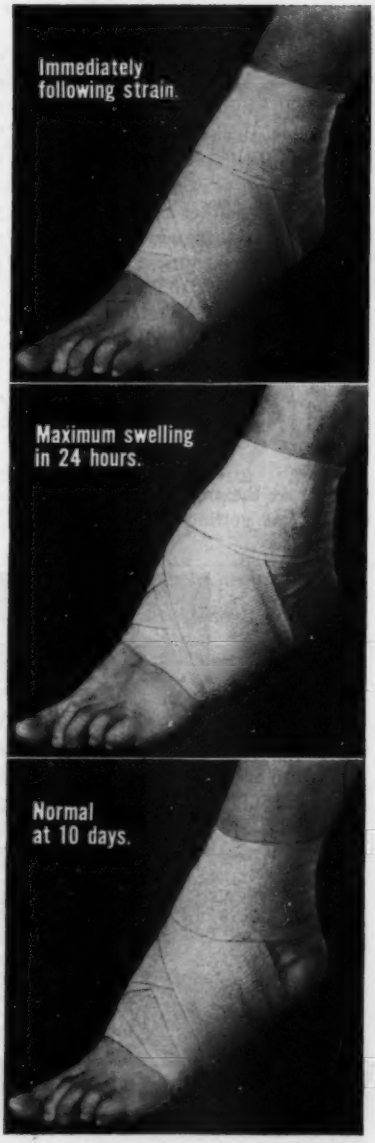
Heat won't affect its elasticity, either. Tensor can be washed and dried in automatic machines—time after time—without losing its "snap."

Shouldn't your patients have the advantages of TENSOR elastic bandage!

NEW FOR DOCTORS
Save 32% when you order in bulk

New TENSOR®
ELASTIC BANDAGE
Woven with Heat-Resistant
live rubber threads

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Division of The Kendall Company
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Other vexing vaccine problems turned up at the start of May. Among the minor ones:

¶ Some vaccine was stolen from a county health office in California.

¶ The Detroit Free Press reported a local gray market in vaccine. And

¶ Confusion reigned in Chicago, where some doctors insisted that National Foundation vaccine should be administered privately—so children could have free choice of physician.

Call It Off?

And there was this major problem, too:

Just as the free-vaccination program was getting off the ground, cases of polio began turning up in children who'd received shots. To take all possible precautions, the Government temporarily halted the distribution of all vaccine. There was some talk, as Public Health Service officials checked vaccine production, that the entire 1955 anti-polio campaign might be called off.

As of May 1, then, it could be said that, in some respects, Salk Season had got off on the wrong foot. But it was clear that most doctors were pitching in with little thought of personal gain. Perhaps one New York City physician summed things up for most doctors when he told me: "I don't need controls. I just need vaccine." END

DOCTOR... WHY SHOULD YOU PRESCRIBE AND RECOMMEND THE NION CALCICAP LINE ?

✓ Perhaps it's because you like the formula.
Dicalcium Phosphate 290 mg.
Calcium Gluconate 190 mg.
Vitamin D (Ir. Yeast) 375 USP Units

✓ Perhaps it's because you like the low patient cost.

✓ Perhaps it's because patient acceptance assures that your medication is actually taken.

For whatever reason,—please continue using the Calcicap® line.

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LESS PAIN
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the **KIDDE** DRY ICE APPARATUS

The "superior cosmetic results" to be obtained with cryotherapy in obliterating verrucae, nevi, angiomas, cystic acne, etc., are well recognized.* But dry ice is cumbersome to obtain and handle.

With the KIDDE DRY ICE APPARATUS, you make your own dry ice as needed, ready for use in a plastic "pencil". Positive pressure control and precise application to the lesion are assured; damage to surrounding tissue or the operator's fingers is avoided. And compared with electrocoagulation or cautery equipment, the cost is insignificant.

If you're not familiar with this ingenious device, ask your surgical dealer to demonstrate.

If you're not acquainted with the many advantages of cryotherapy for removing superficial blemishes, write for literature and reprints.

THE KIDDE DRY ICE APPARATUS *includes applicators in three diameters for treating lesions of various sizes, four cartridges of carbon dioxide, and the unit for making "snow". A full box of 24 Refill Cartridges is included.*



KIDDE

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*J. A. M. A. 118:296, 1942.

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But the most significant fact is told by time. For seven years, AUREOMYCIN has been in daily use, repeatedly employed by thousands of physicians throughout the world. Again and again, it has proved to be a reliable broad-spectrum antibiotic; well-tolerated, prompt in action, effective in controlling many kinds of infection.

A CONVENIENT DOSAGE FORM FOR EVERY MEDICAL REQUIREMENT

Seven years great



7

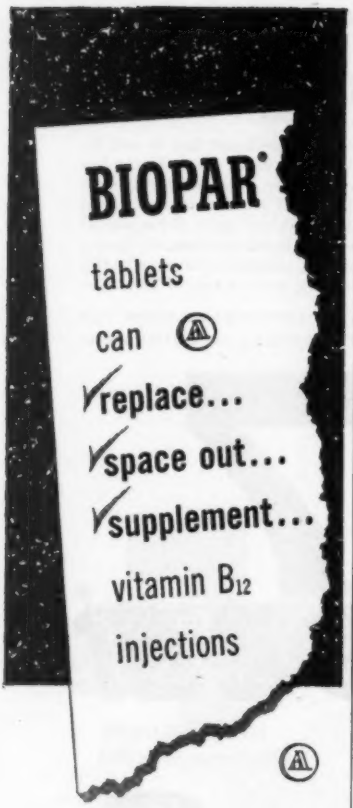
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What Makes a Fee 'Fair'?

[CONTINUED FROM 159]

type of service, regardless of income. Others go along with Dr. James M. Neil of Oakland, Calif., who says:

"A fee is properly set on the basis of the value of the service to a person receiving it. This takes cognizance of the problem presented for solution, the ability of the doctor, and the economic status of the patient."

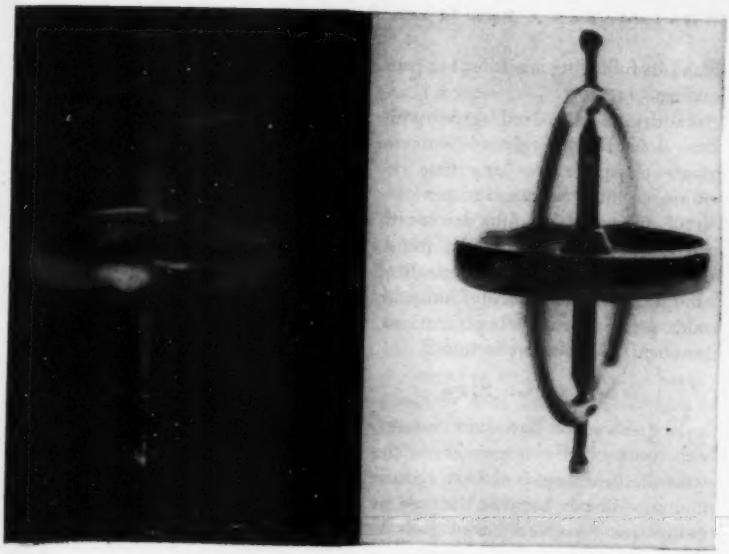
Follow-Up Care

What about charges for follow-up treatment? Most of the doctors queried agree that, in nonsurgical cases at least, such charges should be made only as treatment is given. Dr. Smith's practice of billing in advance for a whole course of treatment is seen by the average grievance committee chairman as a highly suspect form of contract medicine.

It's even worse, in the eyes of an Oregon physician: He attacks Dr. Smith's billing method as "smacking of the advertising rectal specialist's technique."

But even here there are dissenting voices. In some areas, it's fairly common to lump diagnosis, initial treatment, and follow-up care in an all-inclusive fee. Says an Arizona man:

"An experienced doctor knows what to expect in the way of follow-up visits. So it shouldn't be hard to set up an across-the-board charge



a stabilizing agent for the mentally or emotionally disturbed

Unlike the barbiturates, RAU-SED is not a hypnotic when given in proper dosage and will not diminish the patient's alertness. It may be effectively employed as a tranquilizer to relieve tension or anxiety in a wide variety of conditions.

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0.1 and 0.25 mg. tablets, bottles of 100 and 1000

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2 ml. ampuls for parenteral administration, each ml. containing 2.5 mg.

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SQUIBB

for visits following any illness or procedure."

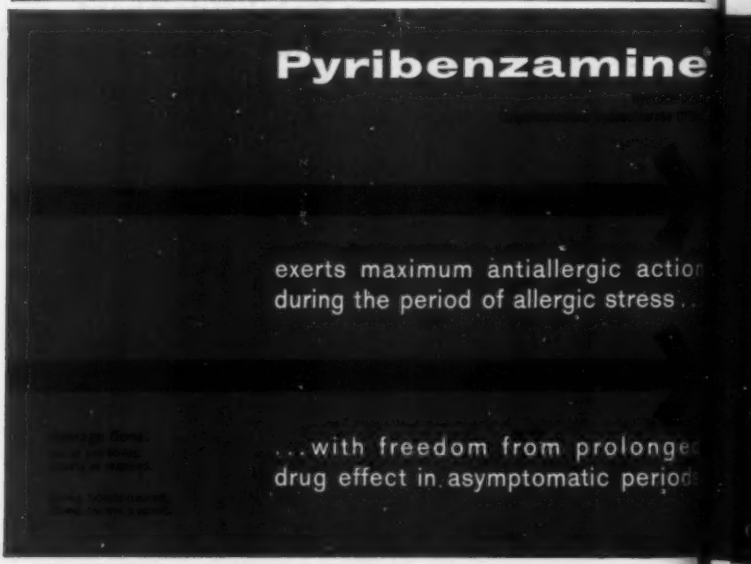
California's Dr. Neil agrees with this view. He strongly advocates a single charge, since "any case requires a total service for completion." He adds that "the lay mind, particularly the insurance lay mind, delights in breakdowns of medical charges. This fits nicely into the sales pitch of many organizations, but bears no relation to facts."

When to Go Slow

Regardless of how fees are set, say most of the respondents, the wise medical man is slow to reduce a charge simply because the patient complains. As a New Yorker puts it: "To immediately offer a 20 per cent reduction [as Dr. Smith did] implies that the fee was too high in the first place. A better way is to discuss the economic situation with the patient after he objects and match the fee to his ability to pay."

Other physicians caution against an even greater danger in too-sudden fee cuts: Such cuts may tempt patients to start malpractice suits. When fees are pared because of inability to pay, these men warn, the patient should be made to understand that his financial situation is the sole reason for the reduction.

Can a panel of physicians pass fair judgment on a colleague's fees? Almost all the medical men sur-



veyed think so. But that's hardly a surprise, since most of them are active on mediation committees.

"Some of us think too highly of our skills and rate them above their worth," says Dr. Edward M. Hayden of Tucson, Ariz. "We need level-headed friends to keep us down to earth."

Was the state society within its rights, then, in scaling down Dr. Smith's fee? Yes, say most of the chairmen; they believe it acted wisely. They also feel that the county society, which neither invited Green to attend its hearing nor notified him promptly of its decision, bungled its role.

"It's understandable, however," one doctor declares. "For in a small local association, physicians hesitate to pass judgment on their friends and colleagues. State medical society men can take a broader view without incurring antagonisms in their own community." Even so, he adds, "it's best for fee disputes to be settled at the county level whenever possible." Another committee head asks, "Who but a local committee can personally know whether a fee is excessive in the light of charges made by men doing similar work in that community?"

While one medical man heard from says "the physician has everything to lose and nothing to gain from grievance committees," this is

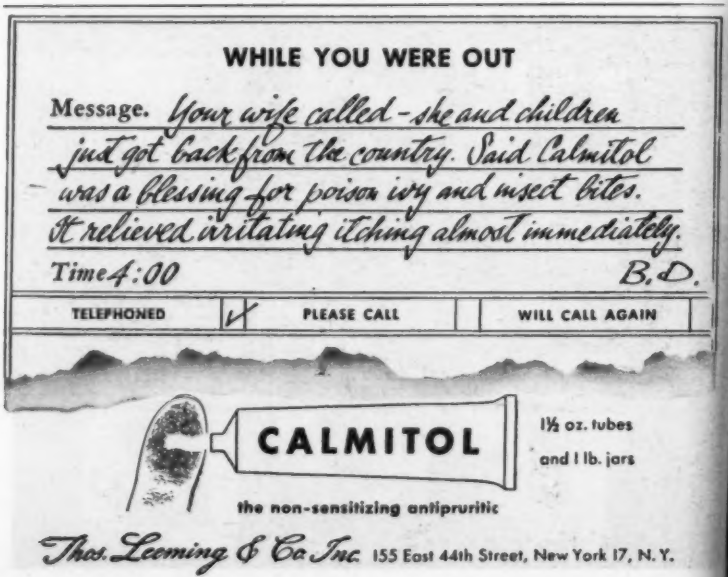


strictly a minority attitude. Most doctors seem to believe that organized medicine can do a lot to minimize physician-patient disputes and that medical societies everywhere are doing a generally good job in this respect, whether through mediation committees or other machinery.

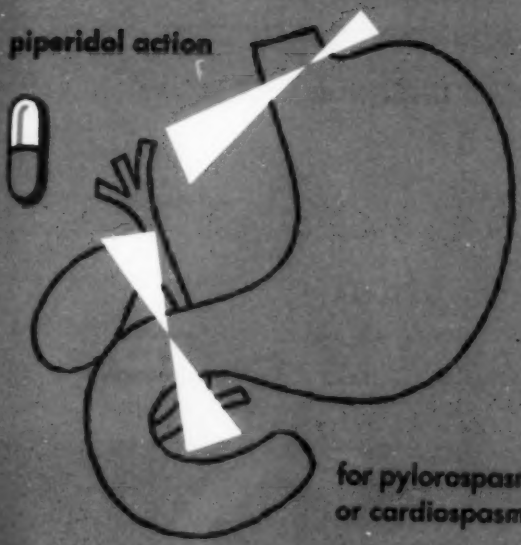
To be sure, no one claims that the treacherous waters of fee setting are easily navigable. And quite a few medical men are frankly weary of having to justify their economic existence to laymen. This feeling is best summed up by a man from upstate New York, who says:

"I've been a physician for twenty-one years; and I often wonder whether it was worth the effort. I'm reminded of the life-saving operations I've seen performed by great surgeons at no charge to the patient . . . of the times the physician stops along the road to give emergency care to people who will never know his name . . . of the investment in time, money, and energy expended by the physician in getting his education.

"The American medical profession has no reason to be on the defensive. It needs no apologists. It gives the public the best medical care in the world. Who can put a dollars-and-cents value on a physician's service but the physician himself?" END



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[CONTINUED FROM 131]

handle TV transmission (he doubles as the hospital's medical photographer). Another man (the maintenance engineer) is on hand in case the receiving sets need adjusting.

The technician sits at his controls in an anteroom, not in the operating room itself. That's possible because the camera works by remote control.

The camera is buried in a cluster of lights directly over the operating table. It can be swiveled, focused, and its lens changed to get magnification, if needed—all from a distance.

Sound comes from a tiny microphone tucked under the surgeon's mask. He can explain his procedures without raising his voice. No one other than the surgical team and the patient need be in the room. The audience is comfortably seated elsewhere.

If a viewer has a question about a procedure, the maintenance man relays it for him by direct telephone wire to the surgeon. The surgeon then answers the question through his microphone so that all the viewers may benefit.

If the surgeon wants to, he can order additional teaching material. Here's a transcript of the start of one operation at a hospital using equip-

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analgesic-antipyretic...
no toxic by-products...

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effervescing analgesic-antipyretic...speeds relief
...assures fluid intake

APROMAL®
(acetylcarbromal and N-acetyl-p-aminophenol, Ames)
sedative-analgesic-antipyretic...calms patients and relieves pain

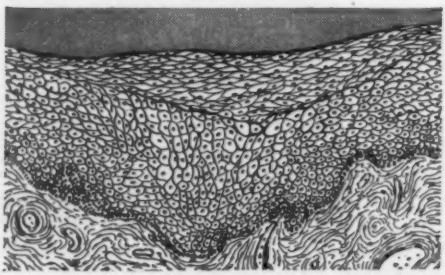
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AMES COMPANY, INC.
Elkhart, Indiana
Ames Company of Canada, Ltd., Toronto

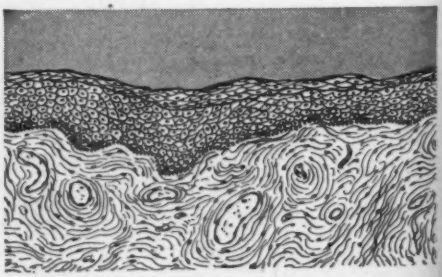
'Target Action' on Vaginal Mucosa

Vallestril, brand of methallenestril, is preferentially indicated whenever estrogens are of value. Its selective "target action" is on the vaginal mucosa with a minimal effect on the endometrium and, therefore, the incidence of withdrawal bleeding is exceedingly low. Also nausea, mastalgia and edema are usually avoided.

"The failure to encounter withdrawal bleeding in any patient was most gratifying . . . unique as well as clinically advantageous."*



Adult vaginal epithelium maintained by estrogen activity.



During menopause, mucosa reverts to the infantile type.

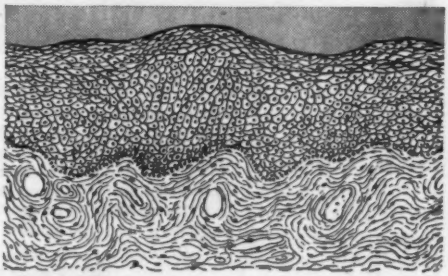
VALLESTRIL® — THE SELECTIVE ESTROGEN

*"Vallestril is an effective synthetic estrogen . . . singularly free from toxic effects and complications, especially uterine bleeding."**

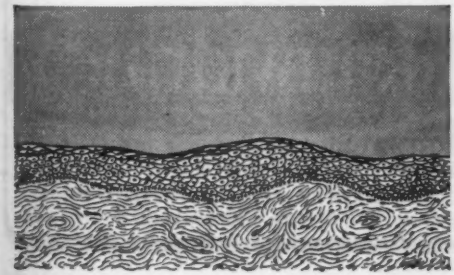
Vallestril quickly controls menopausal symptoms, the pain of postmenopausal osteoporosis and the pain of osseous metastases of prostatic carcinoma.

DOSAGE: Menopause: One tablet (3 mg.) two or three times daily for two or three weeks, followed by one or two tablets daily for one month or longer depending on the patient's response to therapy. Supplied only in scored tablets of 3 mg. G. D. Searle & Co., Research in the Service of Medicine.

*Sturnick, M. I., and Gargill, S. L.: New England J. Med. 247:829 (Nov. 27) 1952.



Vallestril slows transitional phase during menopause.



Postmenopausal mucosa—thinning and atrophy of layers.

SEARLE

ment similar to that in use at St. Vincent's:

"The patient just being wheeled in is, as you can see, an elderly male. He's 68 years old. He has had sedation and a spinal anesthetic. Now, while he is being further prepared for his rectal surgery, let us show some slides of the pathology and the procedure . . ."

Bringing in other educational tools is just one advantage of TV. Here are some others: (1) The size of the audience is practically unlimited. (2) Danger of infection from observers in the operating room is eliminated. (3) Valuable space can be saved in hospital planning because an amphitheatre is no longer needed.* (4) The surgeon need not shift his movements in any way to allow his technique to be seen. (5) Magnified close-ups—as high as twenty-seven times actual size—make it possible for viewers to observe procedures in unprecedented detail.

Students Like It

"Watching on TV is ten times better than straining to get a look from the amphitheatre," says one of the New York University students training at St. Vincent's. "It's the next best thing," he adds, "to assisting

*Some authorities believe, however, that an amphitheatre becomes *more* useful when it uses TV as an adjunct.



FOR APPETITE SUPPRESSION

WITHOUT THE "BLACK MOOD" FEELING OF DEPRIVATION

Rauwidrine—containing 1 mg. Rauwiloid® (alseroxylon fraction) and 5 mg. amphetamine in a single tablet—curtails psychogenic overeating without a feeling of deprivation. Especially welcomed by the depressed and obese patient who needs amphetamine, but who suffers jitteriness, cardiac pounding, and insomnia from amphetamine alone. Safe for the hypertensive, too.

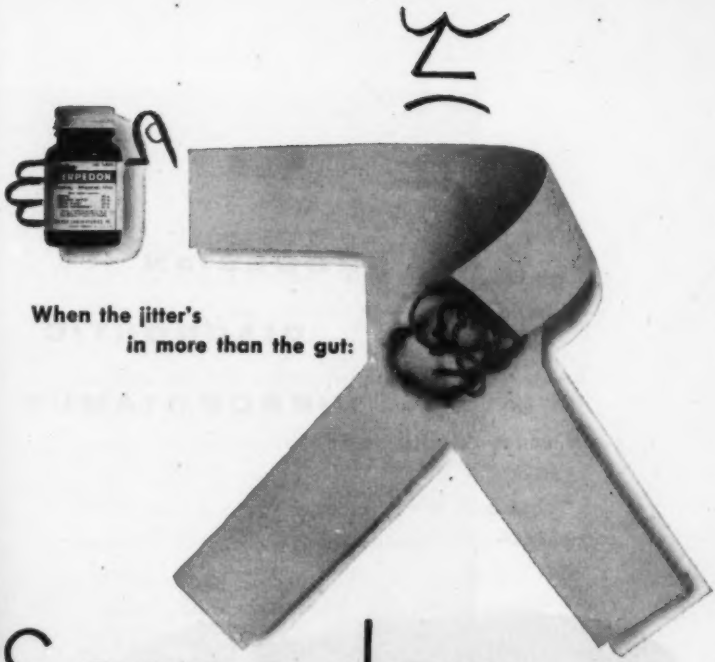
Dosage: For obesity, 1 to 2 tablets 30 to 60 minutes before each meal.

Rauwidrine®

Riker LABORATORIES, INC., Los Angeles



FOR MOOD ELEVATION Rauwidrine provides the needed "lift." Safe for the hypertensive.



When the jitter's in more than the gut:

Serpedon

the tension-easing antispasmodic

Serpedon* helps you treat the jittery patient with the jittery gut, not just his spasm, which is most likely a symptom of his real trouble: anxiety and tension. Serpedon is 0.1 mg. reserpine, plus three alkaloids of belladonna, equivalent to 7 minims of the tincture.

Serpedon rescues the patient from his symptom-producing anxiety and tension with reserpine . . . tranquilizes him, doesn't dull him.

Serpedon stops spasm . . . stops it quickly, gives reserpine time to exert its full, tension-easing effect. Recommended dose is one tablet t.i.d.

Supplied in bottles of 100 scored tablets. *trademark

Walker Laboratories, Inc., Mount Vernon, New York

RHODESIAN DIAGNOSTIC HIPPOPOTAMUS



Courtesy the University Museum of the University of Pennsylvania

Confronted with a sick tribesman, the Barotse medicine man in Northern Rhodesia diagnosed the ailment by placing this delicately balanced hippo on flat ground near the patient. Chanting various "remedies" while dancing around the carved wooden figure, he chose the one uttered at the moment the hippo settled either on its nose or hind legs.

The American physician relies on education and science—rather than hippopotamuses—when diagnosing sickness and selecting remedies. But trying to remember all the effective drugs available might tax his mental balance were it not for PHYSICIANS' DESK REFERENCE—the annual directory of prescription specialties used by more than 130,000 physicians.

PDR PHYSICIANS' DESK REFERENCE

published by Medical Economics, Inc., Oradell, N. J.

the surgeon and feeling the tissues."

That explains why such an institution as New York's Bellevue Hospital has built a television control room into its new operating suite. Dr. Frank Warren, who recommended the installation and also authored the A.M.A.'s new manual on medical TV, believes that such facilities for surgery have become a "must" in planning teaching hospitals.

But surgery isn't all that can be seen effectively on TV. At the Kansas University Medical Center they're moving the "big eye" into the delivery room, the X-ray department (for potential telefluoroscopy), the laboratories, the psychiatric interview rooms, and the clinic area (for endoscopy).

"Television," says Dr. David S. Ruhe, head of audio-visual education at this pioneering center, "has a role in medical teaching at all levels, in research, and in medical care."

What Next?

Some hospitals are even thinking of installing automatic cameras in patients' wards. Objective: to alert staff members when they're needed and to free them for other duties when they're not. In mental hospitals, for instance, a TV monitoring system could substantially relieve the chronic shortage of personnel.

But doctors whose practices are

for the DYSPEPTIC patient

AL-CAROID relieves hyperacidity and aids protein digestion



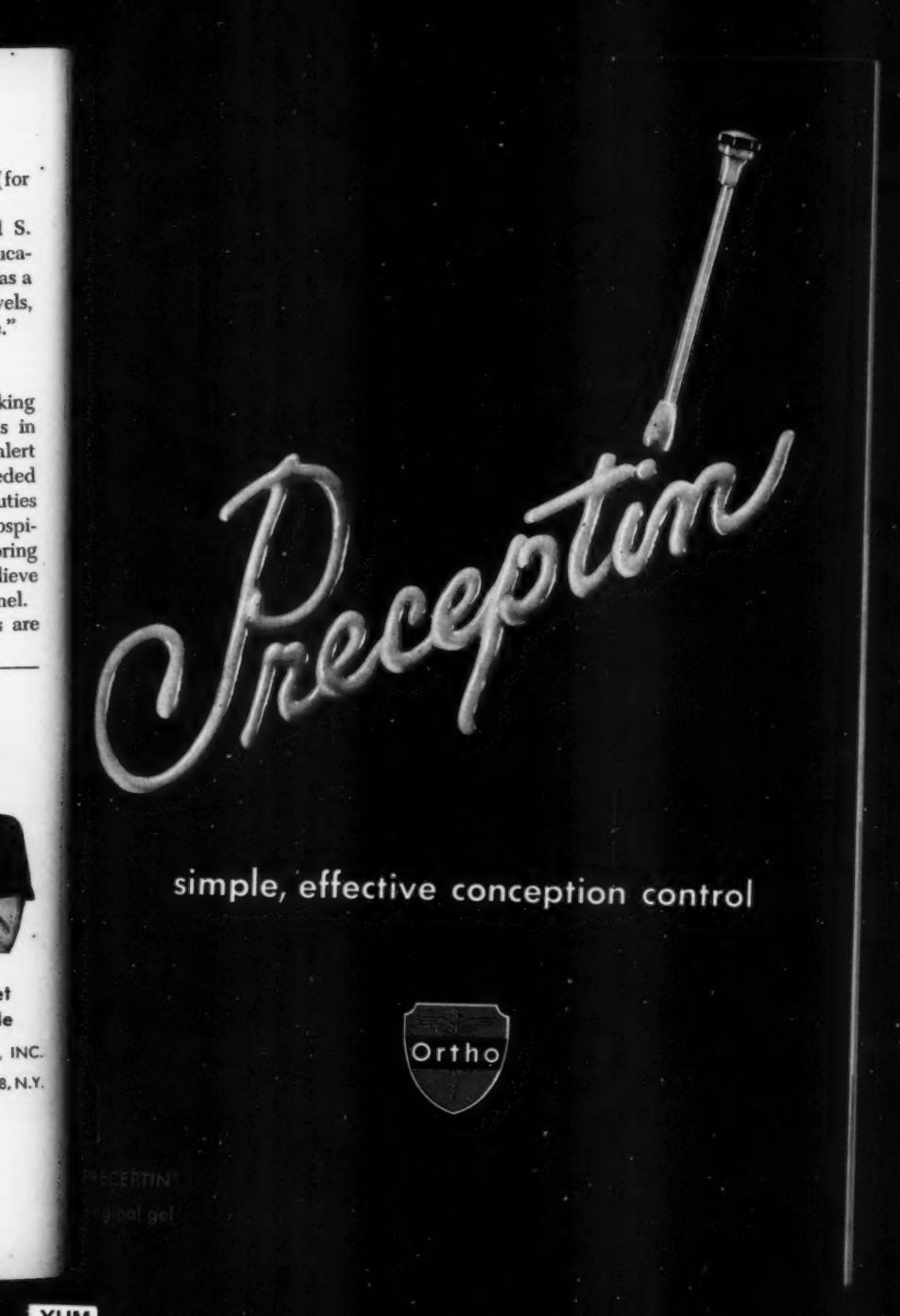
Ordinary antacids inactivate pepsin and thus stop protein digestion, but an in vivo study by Tainter* proves that AL-CAROID, by virtue of its Caroid® content, aids protein digestion while relieving hyperacidity.

*Tainter, M. L., et al: Papain, Ann. New York Acad. Sc. 54:143-296 (May) 1951.

Powder or Tablet Samples Available

AMERICAN FERMENT CO., INC.
1450 Broadway, New York 18, N.Y.

AL-CAROID® antacid-digestant


Preceptin
simple, effective conception control
Ortho

when prescribing a diaphragm



Ortho Kit

Ortho

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They speak for you

Just as the American Medical Association has fought socialized medicine on the American scene, so the World Medical Association has blocked the efforts of the International Labor Organization to introduce socialized medicine on a worldwide scale.

WMA is also actively engaged in *Representing Your Interests* by conducting surveys and taking part in discussions and decisions on such vital issues as:

— standards of medical education
— the effect of social security on medical practice
— the status and distribution of hospitals
— medical manpower
— requirements for practice
— the adoption of a Universal International Code of Medical Ethics

WMA has also cooperated with the International Red Cross, the World Health Organization and similar groups in:

— giving assistance to underdeveloped countries
— the distribution of scientific, social and economic medical information
— holding forums for the discussion of international medical affairs
— calling the First World Conference on Medical Education

you can't afford to be out of touch with an organization that represents you in such varied and vital matters

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what affects world medicine affects you

WMA is Approved by the American Medical Association

Dr. Louis H. Bauer, Secretary-Treasurer
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(Contributions are deductible for income tax purposes)

Make checks payable to the U.S. COMMITTEE, WORLD MEDICAL ASSOCIATION

this is your only voice in world medicine

When you specify the Pfizer antibiotic of your choice *Stress Fortified* with the B-complex, C and K vitamins recommended by the National Research Council, be sure to write SF* on your prescription

antibiotics *Stress Fortified* with vitamins include:

Terramycin®-SF

Brand of oxytetracycline with vitamins

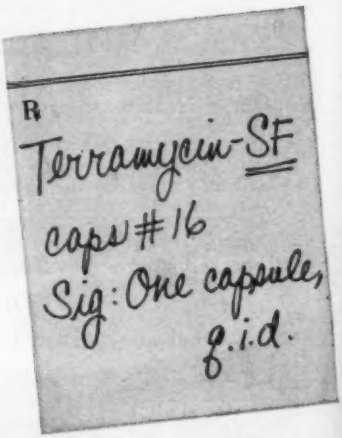
CAPSULES 250 mg.

Tetracyn®-SF

Brand of tetracycline with vitamins

CAPSULES 250 mg.

ORAL SUSPENSION (fruit flavored)
125 mg./5 cc. teaspoonful



The minimum daily dose of each antibiotic *(1 Gm. of Terramycin or Tetracyn, or 600,000 units of penicillin)* **Stress Fortifies the patient** *with the stress vitamin formula* **recommended by the National Research Council:**

Ascorbic acid, U.S.P.	300 mg.	Calcium pantothenate	20 mg.
Thiamine mononitrate	10 mg.	Vitamin B_{12} activity	4 mcg.
Riboflavin	10 mg.	Folic acid	1.5 mg.
Niacinamide	100 mg.	Menadione (vitamin K analog)	2 mg.
Pyridoxine hydrochloride	2 mg.		

*Trademark

Pfizer

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N.Y.

centered in hospitals aren't the only ones keeping a sharp eye on TV. The new medium shows signs of breaking in on *every* M.D.'s practice. For instance:

Intercity Consultation

Consultation by TV has already been tried experimentally—and with some success. As costs of equipment and facilities go down (they're bound to, in response to growing demand), more intercity consultations are apt to take place. Images of X-ray plates, microscope slides, electrocardiograms, and other diagnostic data can be transmitted instantly.

New TV technical devices are being developed so fast that you may soon be able to watch televised clinics and symposia in your own office or home. Through the air will come what's known as a scrambled image—a picture that will appear clear on your screen only if your set is specially adjusted for that purpose. But that will be easy to do.

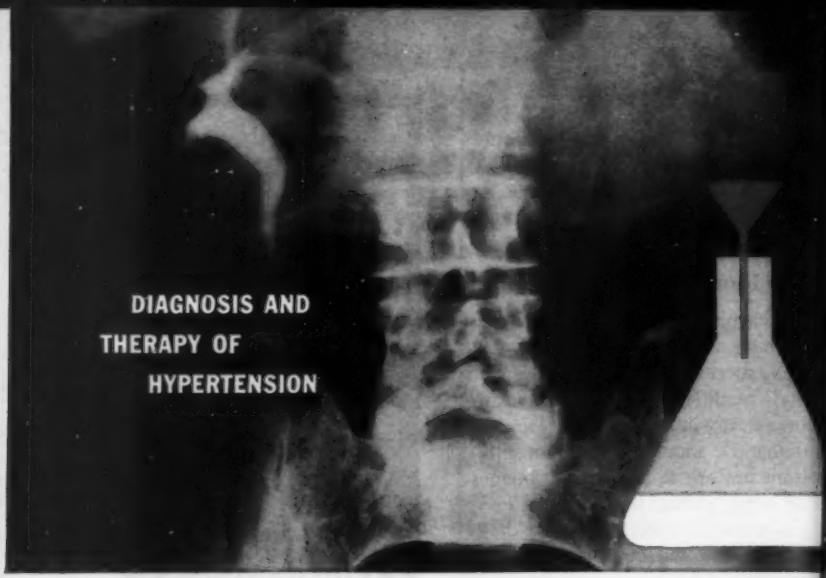
Your 'Private Eye'

By some such device as an extra set of dials that respond only to a prearranged private code number, you'll be able to tune in from your living room on a for-doctors-only program from, say, the Mayo Clinic. It'll be that simple.

It will, that is, if your small fry don't insist then on having the set tuned to the 1957 version of Howdy Doody instead. END



*T.M. Reg. U.S. Pat. Off.



kidney damage

In the diagnosis of hypertension, kidney damage can be recognized by *two* commonly used methods: blood chemistry may indicate functional inadequacy; the retrograde pyelogram reveals structural damage.

In the therapy of hypertension, also, *two* agents may be used for better control and greater safety. Methium with Reserpine combines the potent ganglionic blocking action of hexamethonium with the mild hypotensive and sedative effects of reserpine. "...this combination accomplishes a more stable reduction of blood pressure than that achieved with hexamethonium alone."* Synergism between the two agents permits reduced dosages, thus minimizing the risk of side effects.

Because of the potency of Methium, careful use is required. Caution is indicated in the presence of renal, cardiac or cerebral arterial insufficiency. Markedly impaired renal function is usually a contraindication.

Supplied: *Methium* 125 *with Reserpine*—scored tablets containing 125 mg. of Methium and 0.125 mg. of reserpine. *Methium* 250 *with Reserpine*—scored tablets containing 250 mg. of Methium and 0.125 mg. of reserpine.

*Dennis, E.; McConn, R. G.; Ford, R. V.; Hughes, W. M.; Beazley, H. L., and Moyer, J. H.: Postgrad. Med. *16*:300 (Oct.) 1954.

Methium® with Reserpine

CHLORIDE

(BRAND OF HEXAMETHONIUM CHLORIDE)

"a perfect match"

WARNER-CHILCOTT

Are Surgical Fees Too High?

[CONTINUED FROM 101]

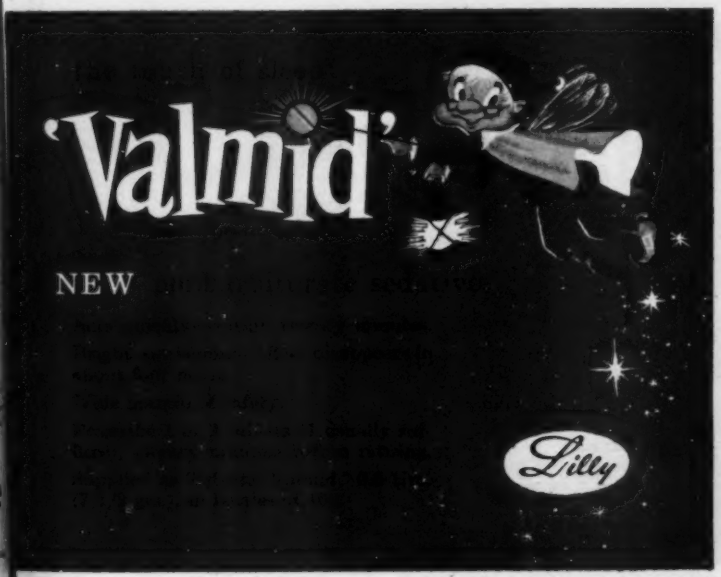
syndrome. After several visits and many laboratory tests, I decided she needed a bilateral adrenalectomy. But there was also a chance of cancer. So I wanted to examine both the adrenal glands and the ovaries before the surgeon took any of them out.

I was in the operating room the full time. I looked at the organs in question as they were uncovered. And I made the final decision that all of them ought to come out.

The surgeon finished his work in about two hours. I was with the patient all day—more than eight hours—to make sure her condition remained satisfactory. In addition, of course, I visited her daily (sometimes more often) during her month in the hospital before the operation and during her two weeks after it.

For all this—and for all her office visits and laboratory tests—I sent the patient a bill for $300. The surgeon's fee for his two-hour operation was $500.

In a good many operative cases, as in this one, the medical man's work is at least as vital as—and far more time-consuming than—that of the surgeon. But you wouldn't think



so, to judge by the size of their respective fees.

No, the surgeon hasn't lowered his fees now that he no longer has to split them. Instead, he has, in effect, raised them—and not merely in the big cities. Judging from comment I've heard all over the country, the price of surgery comes high everywhere.

Extra Training?

An occasional surgeon tries to justify his charges by citing his extra years of training. But this argument simply doesn't hold water. The surgical specialty takes no more extra training than many nonsurgical specialties.

Another argument is that higher operating costs necessitate higher fees. Well, here are the facts:

The Seventh MEDICAL ECONOMICS Survey shows that surgeons have the fourth lowest overhead among the twelve major specialties. The median expense figure for surgeons is 36 per cent of gross income, while the comparable figure for general practitioners is 41 per cent. Nor do these figures tell the whole story.

The office expenses of quite a few surgeons are almost nil. Unlike the G.P. or internist, the surgeon doesn't require room after room full of diagnostic and therapeutic paraphernalia. Some surgeons don't even *have* offices!

[MORE ▶

BASIC IN HYPERTENSION

'Sandril'

(RESERPINE, LILLY)

In hypertension, 'Sandril' often produces the desired reduction of blood pressure. In severe cases, 'Sandril' supplements the action of 'Provell Maleate' (Protoveratrine A and B Maleates, Lilly).

SUPPLIED:
Tablets—0.1, 0.25, and 1 mg.
Elixir—0.25 mg. per 5-cc. teaspoonful.

Lilly



"Gardening hard work? Not when you're in good shape!"



Physical fitness is enjoyed at any age, but during the later years it is especially coveted. GEVRAL supplies all the vitamins and minerals the older patient may need to continue feeling young at heart.

Gevral*

Geriatric Vitamin-Mineral Supplement Lederle

EACH GEVRAL *CAPSULE CONTAINS:*

Vitamin A	5000 U.S.P. Units
Vitamin D	500 U.S.P. Units
Vitamin B_{12}	1 mcgm.
Thiamine Mononitrate (B_1)	5 mg.
Riboflavin (B_2)	5 mg.
Niacinamide	15 mg.
Folic Acid	1 mg.
Pyridoxine HCl (B_6)	0.5 mg.
Ca Pantothenate	5 mg.
Choline Dihydrogen Citrate	100 mg.
Inositol	50 mg.
Ascorbic Acid (C)	50 mg.
Vitamin E (as tocopheryl acetates)	10 I. U.
Rutin	25 mg.
Purified Intrinsic Factor Concentrate	0.5 mg.
Iron (as $FeSO_4$)	10 mg.
Iodine (as KI)	0.5 mg.
Calcium (as $CaHPO_4$)	145 mg.
Phosphorus (as $CaHPO_4$)	110 mg.
Boron (as $Na_2B_4O_7 \cdot 10H_2O$)	0.1 mg.
Copper (as CuO)	1 mg.
Fluorine (as CaF_2)	0.1 mg.
Manganese (as MnO_2)	1 mg.
Magnesium (as MgO)	1 mg.
Potassium (as K_2SO_4)	5 mg.
Zinc (as ZnO)	0.5 mg.

Other Lederle geriatric products include: GEVRABON* Vitamin-Mineral Supplement liquid with a wine flavor; GEVRAL* Protein Vitamin-Mineral-Protein supplement powder; and GEVRINE* Vitamin-Mineral-Hormone capsule.

*REG. U.S. PAT. OFF.

Lederle LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

Often it's the community, through its hospital, that provides the surgeon with the tools, equipment, and space he needs to practice. For his instruments, operating rooms, nurses, and hospital aides, he pays precisely nothing. So can he really justify high fees on grounds of increased overhead?

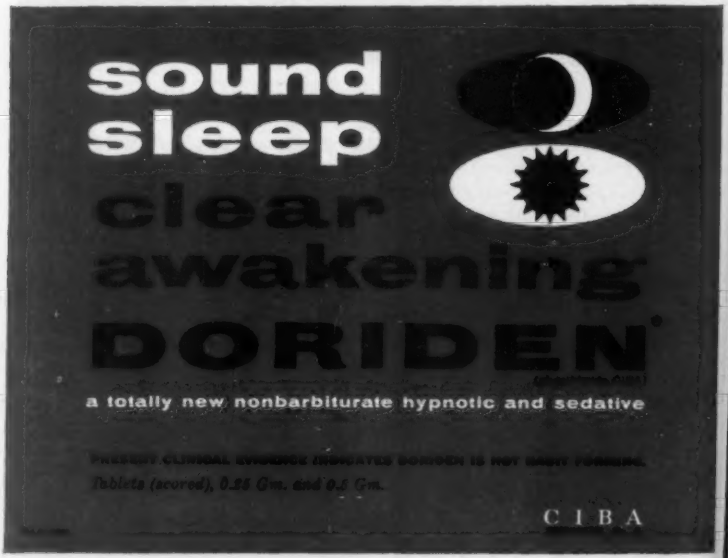
Insurance Contracts

It's true, of course, that surgical fees are set high in insurance contracts. But who sets them?

To answer that question, consider the make-up of the medical hierarchy in most communities: The general practitioner, who's admittedly the backbone of American medicine, has little or no time to engage in medical society activities. MEDICAL ECONOMICS studies show that the average G.P. works sixty-two hours a week, as against the surgical specialist's fifty-four hours a week.

And many surgeons put in much less time than the average. Often they finish their hospital work in the morning and are free a good part of the rest of the day. They therefore have more time for organizational work than most other physicians. Result: Our medical societies are not merely specialist-dominated; they're surgeon-dominated.

I'll cite just one example among many: Of the medical men who served in 1954-55 on the council



PEDIATRICS BULLETIN

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

IMPORTANCE OF URINALYSIS FOR SUGAR IN SICK INFANTS

IT IS TRAGIC to fail to detect even a rare disease if therapy is possible. Galactosemia, a rare congenital anomaly of metabolism, can be fatal or cause blindness and is probably much more common than reported. However, nearly normal health can result simply from early recognition of this condition and the elimination of sources of galactose in an infant's diet. A positive sugar reaction in the urine of an infant is alone adequate in directing one's attention reliably to the possibility of galactosemia. Routine urinalysis with Benedict's test, so customary in child and adult care, is not routine in young infants since it is difficult to obtain a specimen and since diabetes is so rare that the probability of glycosuria is small. Nevertheless, in infants who are not doing well, surely a urinalysis is indicated, even at the cost of considerable effort to obtain a sample of urine. No positive sugar reaction should be discarded as an error in technique or due to transitory alimentary glycosuria until the test is repeated and the nature of the reducing substance if persistent, is determined.



NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and appear periodically in Medical Economics.

HEINZ
OVER 60 KINDS—Including New Heinz Strained and Junior Meats
Baby Foods
You Know It's Good Because It's Heinz!
57 Symbol Of Fine Quality Since 1869



destroys pneumococci...

This sensitivity test shows a strain of *Diplococcus pneumoniae* on a blood agar plate. Note the high activity of ERYTHROCIN against this organism. This same pneumococcus is often associated with *otitis media . . . bronchitis . . . empyema . . . pericarditis . . . peritonitis . . . conjunctivitis . . . sinusitis . . .* and *pneumococcal pneumonia.*

specific against coccic infections...

Now, you can prescribe an antibiotic (*Filmtab* ERYTHROCIN) that provides *specific therapy* against staph-, strep- or pneumococci. Since these organisms cause most bacterial respiratory infections (*and since they are the very organisms most sensitive to* ERYTHROCIN) doesn't it make good sense to prescribe ERYTHROCIN when the infection is coccic?

filmtab

Erythrocin®

(Erythromycin Stearate, Abbott)

STEARATE

STEARATE



...with little risk of serious side effects

Since ERYTHROCIN is inactive against gram-negative organisms, *it is less likely to alter intestinal flora—with an accompanying low incidence of side effects.* Also, your patients seldom get the allergic reactions sometimes seen with penicillin. Or loss of accessory vitamins during ERYTHROCIN therapy. *Filmtab* ERYTHROCIN (100 and 200 mg.) in bottles of 25 and 100. Abbott

filmtab

Erythrocin®

(Erythromycin Stearate, Abbott)

STEARATE

®Filmtab—Film sealed tablets; patent applied for.

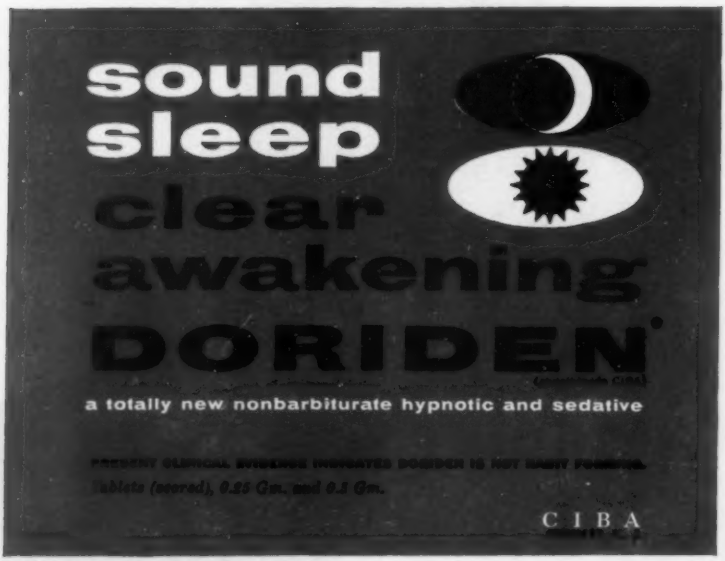
that coordinates the activities of the five county medical societies in Greater New York, sixteen out of twenty-two were surgeons.

Naturally, then, since fees in insurance plans are determined by the medical societies, surgical fees remain high. This in spite of the abolition of fee splitting, the increase in insurance, and the fact that surgical overhead is paid for largely by the community!

As we all know, too, the surgical fees described in voluntary health policies are often augmented by additional sums that the surgeon charges over the amount contracted for. In the Blue Shield plans, only the patient whose income is small enough to entitle him to service-type coverage avoids such extra levies.

In the days when fee splitting was rampant, one of the criticisms leveled against it was that it encouraged unnecessary surgery. Has the abolition of fee splitting caused this evil to disappear? It would seem not.

As late as January, 1955, a hospital investigator for the American College of Surgeons described unnecessary surgery as the greatest problem facing American medicine. In a paper for the A.C.S. bulletin, he stated further that a majority of the medical profession gives "general acceptance and tolerance to, and even total inattention to . . . the unnecessary, unethical and ofttimes



Modern
Unique
Exclusive

new



Cortril® Vaginal tablets

brand of hydrocortisone

Using CORTRIL Vaginal Tablets as supportive therapy in conjunction with usual measures, 18 investigators* treated monilial, trichomonal, senile, allergic, and nonspecific vaginitis. They obtained a good to excellent response in 90 per cent of patients.

CORTRIL, by virtue of its anti-inflammatory action, reduces local edema and inflammation in vaginitis. The resultant relief from vulvovaginal itching and discharge is often obtained within minutes or hours, as contrasted with two to three days with ordinary measures.

administration: Insertion of 1 or 2 tablets daily. **supplied:** 10 mg. tablets.

Personal communications

PFIZER LABORATORIES *Division, Chas Pfizer & Co., Inc.* Pfizer *Brooklyn 6, New York*

big
benefits
for
small
patients

ABDEC®
DROPS



ABDEC DROPS give your youngest patients dependable multivitamin support, so important to optimal growth and development. A stable, nonalcoholic formulation—concentrated for easy administration—**ABDEC DROPS** mix readily with food, fluid, or formula, or may be placed directly on the tongue. There is no need for refrigeration.

Parke, Davis & Company

criminal surgery practiced by an affluent, politically powerful minority." And he added: "In one hospital more than 50% of the appendices, tubes, ovaries and uteri removed were without gross or microscopic evidence of disease."

Highest Net Income

There's an obvious reason for the high incidence of such needless operations: Too many men have taken up surgery for financial gain, rather than because of a valid interest in the specialty. They're drawn by the fact that, among all the major specialties, surgery commands about the highest median net income ($16,000, according to the last MEDICAL ECONOMICS survey). It's not surprising, then, that the field has become crowded and that competition is brisk.

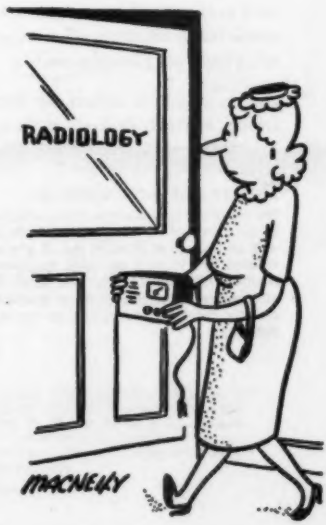
I'd like to touch now on the subject that's avoided almost entirely at medical meetings but that's discussed whenever doctors congregate in private: the growing schism in medicine between the surgeon and the rest of the profession.

We can ill afford at this time the luxury of internecine warfare. The present Administration in Washington favors the free enterprise system in industry and in medicine. But what of the future? We ought to be consolidating our forces during the current interlude rather than dividing them.

Surgery's critics find cause for complaint at two levels: the professional and the economic. At the professional level, the general physician resents the almost menial part he's forced to play in the eyes of the public. He knows the importance of his role in the diagnosis, preparation for operation, choice of surgery and surgeon, postoperative care, and—most important—constant reassurance of the patient and his family. But what he does is too often minimized by patient and surgeon alike. This wouldn't be so if the surgeon tried to redress the balance, as he should.

As for the economic problem—it has several facets. For example:

Often, voluntary insurance pays the surgeon but not the referring



in rheumatoid

more effective therapeutic agent than older corticosteroids

Three to five times as potent as oral cortisone or hydrocortisone, milligram per milligram, METICORTEN provides enhanced anti-inflammatory and antirheumatic action without the major undesirable effects associated with older corticosteroids.

Within 24 hours after administration of METICORTEN, joint pain decreases, and stiffness and local heat diminish. Improvement in functional capacity and mobility follows quickly.[1,2] Excellent results are obtained even in patients no longer responding to cortisone or hydrocortisone.[1,2]

And in intractable asthma, METICORTEN controls symptoms rapidly, markedly increases vital capacity, and permits patients to resume normal activities promptly.[3,4]

Dosage and Administration

METICORTEN is available as 5 mg. scored tablets in bottles of 30 and 100. In the treatment of rheumatoid arthritis, dosage of METICORTEN begins with an average of 20 to 30 mg. (4 to 6 tablets) a day. This is gradually reduced by 2½ to 5 mg. until maintenance dosage of 5 to 20 mg. is reached. The total 24-hour dose should be divided into four parts and administered *after meals and at bedtime*. Patients may be transferred directly from hydrocortisone or cortisone to METICORTEN without difficulty.

d arthritis

"...free of significant metabolic, water or electrolyte disturbances."[1]

The higher therapeutic ratio of METICORTEN permits marked clinical benefits unaccompanied by many of the major undesirable actions characteristic of cortisone and hydrocortisone.[1-4]

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- avoids weight gain due to edema
- no excessive potassium depletion
- better relief of pain, swelling, tenderness; diminishes joint stiffness
- lowers sedimentation rate even where cortisone or hydrocortisone ceases to be effective—"cortisone escape"
- most effective in smallest dosage

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physician, regardless of the magnitude of his job. Those casual words, "My insurance will take care of it," have become a travesty to the family doctor.

Sometimes, the surgical fee is so high that the G.P., knowing full well the economic status of his patient, is reluctant to add a charge of his own. If he *does* do so, he may be asked impolitely, "What did *you* do?" or told that "I've *already paid* for my operation."

A well-chosen word from the surgeon could obviate many of these difficulties. And further activity by the insurance committees of county and state medical societies could correct the others.

What Lower Fees Mean

What might we hope to gain by a program of reduction in surgical fees? Here are some of the potential benefits:

1. If we could bring the price of surgical and medical care more nearly within the reach of our population, much of the clamor for government intervention in medicine would be silenced. Just remember that there's a protagonist for medical care by government in every individual who's had a hard time paying for a costly operation.

2. We would improve the profession's deteriorating public relations. As individuals, we doctors are pretty universally respected; but as a profession, we're often viewed as a group of high-handed money-

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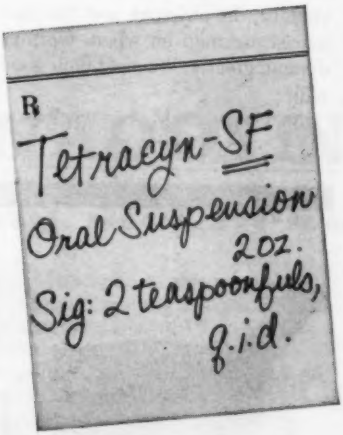
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grabbers, profiting from the ills of our fellow men.

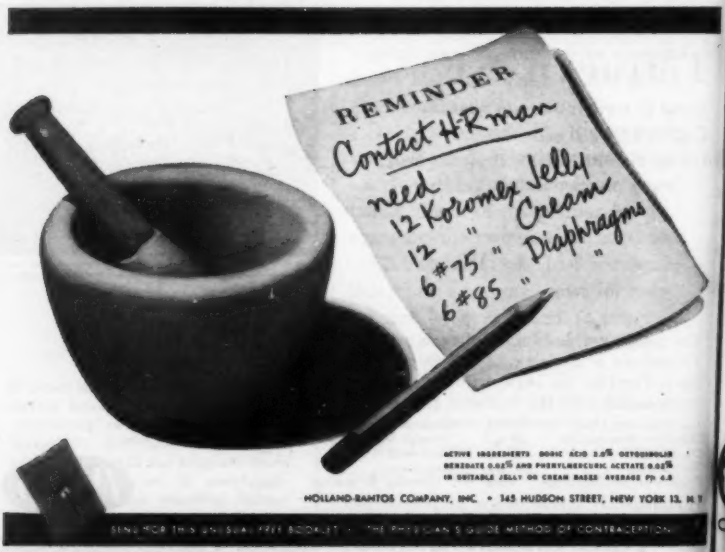
3. If the current discrepancy between surgical and other fees no longer existed, medical men would tend to distribute themselves more realistically among the other specialties and in general practice.

4. A voluntary move to reduce the cost of surgical care—and, often, our own incomes—would be of paramount importance in establishing better rapport with practitioners of our basic science professions. The chemist, the physicist, and the pharmacist are men on whom we must depend greatly. We need their goodwill.

5. There could be no greater stimulus to the growth of the voluntary health insurance plans (which most of us back strongly) than the acceptance by the surgeon of the fee stipulated in the contract as full recompense for work performed. Many policyholders now feel they're only half insured; and their displeasure at having to pay surgical fees in addition to insurance premiums is intense.

6. If there were *fewer* surgeons, each working *more* hours per day, their incomes might well remain the same, even with lower fees. Meanwhile, the public and the profession as a whole would benefit from the better surgery practiced by individuals with ever greater experience.

END





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1. Weinberg, Arthur and Werner, W.E.F.: Bonadoxin, a new effective oral therapy for hyperemesis gravidarum. Am. Pract. and Dig. of Treatment. In press. 2. Personal communication. 3. Berenson, F.: Bonadoxin: oral therapy for nausea and vomiting of pregnancy. In press.

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The occasion for this brief salute is the tenth anniversary of the reorganization of the American Cancer Society and the launching of the post-war attack on cancer. Much has been achieved—far more remains to be done. We count heavily on the doctor in our house.

American Cancer Society

Panorama

[CONTINUED FROM 14]

inoculation of Richmond school children. The announcement appeared to assume that local doctors would give their blessing; but it overlooked their determination not to endorse the Salk vaccine until after release of the Francis report.

The City Health Director, Dr. Edward M. Holmes Jr., bridled at this cavalier attitude toward the home-town medical team. He commented that his official position empowered him to authorize mass inoculations, but that he hadn't done so —and he didn't intend to, until the plan was approved by the board of health, the school board, and the Richmond Academy of Medicine.

One basic reason for Dr. Holmes' indignation: Under his direction, Richmond had been one of seven Virginia communities in which the foundation conducted field trials of the Salk vaccine. Four thousand Richmond children had received three shots each; a control group had received none. Yet the foundation's 1955 plan for mass inoculations included the control group. Thus, charged the doctor, the foundation's program would wreck any study of the duration of immunity.

His opposition brought the local machinery of the National Foundation to a shuddering stop. Result: confusion on the pediatric front.

Parents who now feared their children might miss the foundation's free vaccine began to besiege their private physicians for tentative promises of inoculation. Doctors' secretaries started drawing up waiting lists and scheduling distant appointments, meanwhile trying to remember which appointments might be canceled if the foundation program went into effect over the City Health Director's objections.

A typical anxious mother wrote an "indignant protest" to a Richmond newspaper; she called Dr. Holmes' opposition to mass inoculation "nothing short of tragic." A defender of foundation policy spoke up in the Virginia State Health Department: "It would be inhuman to withhold" the vaccine for the sake of preserving an unnecessary control group, said Dr. Mason Romaine.

But Holmes still urged caution. When the City Board of Health convened to discuss the matter, he summed up his attitude toward the foundation's plan in the caustic phrase, "dimes versus science." Even so, the board gave tentative approval to the program, though it withheld authorization of inoculations until after release of the Francis report.

On April 13, twenty-four hours after the report was made public, the Richmond Academy of Medicine voted unanimously to approve the foundation's plan for free mass inoculation of school children. In addition, it recommended voluntary rationing of the vaccine by local

doctors, and it approved distribution through retail druggists.

It concluded the evening's business, however, by putting through a formal recommendation that "the relationship between national health organizations and local and state public health agencies and medical societies be reviewed, in order that misunderstandings and difficulties . . . may be avoided in the future."

The Academy president, Dr. Benjamin Rawles Jr., permitted himself a discreet admission that "there has been some question raised as to how the Salk vaccine program has been handled." Public clamor for the vaccine after the foundation's premature announcement, he said, had "nullified effectiveness of the approving medical bodies, because approval at best could only be given on a public demand basis" rather than on a basis of "sound and unbiased scientific appraisal."

On the same evening, the board of health okayed the foundation's program. The way was clear at last for mass inoculation of school children as planned.

One curious phenomenon was pointed out by observers, though: The percentage of parents giving consent for inoculation with free vaccine from the foundation was noticeably lower in Richmond than elsewhere. Doubtless because of the squabble, only some 80 per cent



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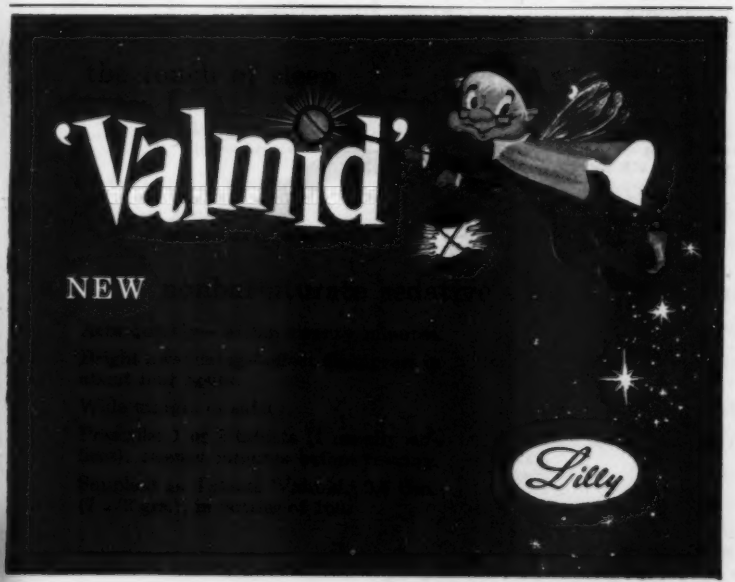
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of the city's eligible children were given permission—as against well over 90 per cent in other parts of the state. One Richmond mother is quoted as having said: "I don't know . . . After all, the City Director of Health is against it . . ."

Then, too, just as peace appeared imminent, the foundation dropped another match into the Richmond tinder: It announced it would offer school children only two free shots, instead of the recommended three. The third, it suggested, should be arranged for from public health departments or from private physicians. Within hours, Dr. Holmes was again on the warpath.

He said it was "reprehensible and arbitrary" for the foundation to back down on its promise of three shots. He declared the Richmond Health Department had no funds to buy vaccine for give-away booster shots. And he insisted that, with the foundation's budget for next year "anticipated to be over $60 million," he would "die fighting any move" to raise money by a public appeal.

"I think Dr. Holmes is perfectly correct in being upset," says Academy President Rawles. But Dr. Hart Van Riper, medical director of the National Foundation for Infantile Paralysis, disagrees: Dr. Holmes, he says, "is the first person in the country to adopt an unfavorable reaction to the foundation program." END



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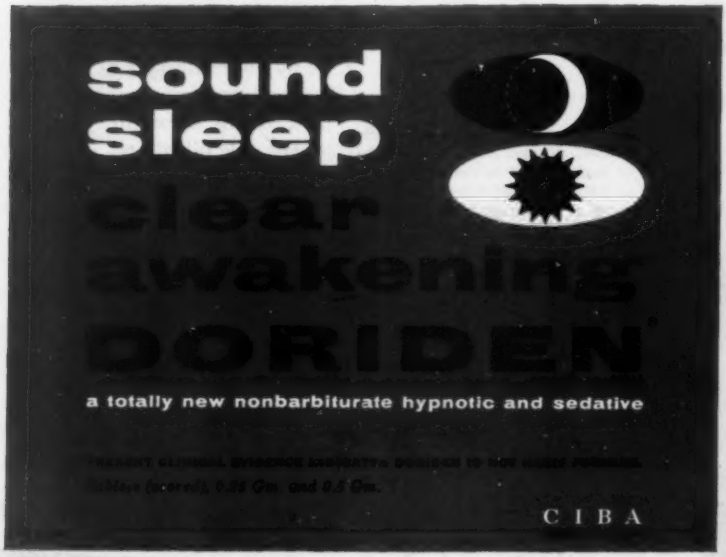
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Altepose®

keeps your patient co-operative on a diet

MAJOR ADVANTAGES: 1. Overcomes excess craving for food. 2. Reduces tissue water retention. 3. Alleviates nervousness and irritability.



Prompt results from ALTEPOSE therapy will encourage your patient to remain on the diet you prescribe. ALTEPOSE works in three effective ways to help your patient reduce.

The *Propadrine*® content controls the appetite, yet causes less central nervous stimulation than amphetamine. *Delvinal*® lessens the irritability so often associated with stringent diets. *Thyroid* brings about weight loss *early* in the dietary period, through release of tissue-bound water.

Each ALTEPOSE Tablet contains 50 *mg.* 'Propadrine' HCl, 40 *mg.* thyroid and 25 *mg.* 'Delvinal' vinbarbital. *Supplied* in bottles of 100 and 1000.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

Now in their 9th year of service to busy doctors



. . . the time-saving

IVORY HANDY PADS

Nearly nine years ago Ivory Soap offered its first Handy Pads as a free service to physicians. Today, more doctors are ordering and using Ivory Handy Pads than ever before.

The reason for this continuing and growing popularity is plain. The Ivory Handy Pads effectively perform a valuable double service: 1, They simplify the doctor's task of giving certain routine instructions—thus saving valuable time; and 2, They provide the patient with the necessary instructions in a permanent form, always easy to consult—thus increasing the prospect of satisfactory cooperation.

Why not see for yourself how helpful this service can be? Without cost or obligation you can obtain any or all of the six different Ivory Handy Pads.

YOU CAN OBTAIN—FREE—ANY OR ALL OF THE IVORY HANDY PADS

Write, on your prescription blank, to Procter & Gamble, Dept. C, Box 687, Cincinnati 1, Ohio



99 44/100% Pure • It Floats

Ask for the Handy Pads you want by number.
No cost or obligation.

No. 1: "Instructions for Routine Care of Acne."
No. 2: "Instructions for Bathing a Patient in Bed."
No. 3: "Instructions for Bathing Your Baby."
No. 4: "The Hygiene of Pregnancy."
No. 5: "Home Care of the Bedfast Patient."
No. 6: "Sick Room Precautions to Prevent the Spread of Communicable Disease."

